91

Supreme Court, U.S.
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No. (1)

In the Supreme Court of the United States

RUTH AROCHO, As Administratrix of the ESTATE OF ENRIQUE RENE VERAS, WADAYS VERAS, and RUTH AROCHO As Parent and Natural Guardian of Crystal Veras,and Yashera Veras
Petitioners

-vs-

COUNTY OF LEHIGH and DALE MEISEL,
Respondents

On Petition for Writ of Certiorari to The Supreme Court of Pennsylvania

PETITION FOR WRIT OF CERTIORARI AND APPENDIX VOLUME I

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QUESTIONS PRESENTED

This Court defined "deliberate indifference" for purposes of an Eighth Amendment violation as "know[ing] that inmates face a substantial risk of serious harm and disregard[ing] that risk by failing to take reasonable measures to abate it." The Pennsylvania Courts held that the test of reasonableness required actual knowledge by prison officials that the measures were unreasonable, and applied a blanket prohibition to the introduction of prevailing corrections standards.

The questions submitted for review are

1. Whether *Farmer v. Brennan* applies a standard of objectively reasonable to the measures taken to abate a known risk of harm?

2. Whether this Court's decision in *Bell v. Wolfish* precludes consideration of industry standards as part of the quantum of evidence that the response to a known risk was unreasonable?

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CITATIONS TO THE OFFICIAL AND UNOFFICAL REPORTS OF THE OPINIONS AND ORDERS ENTERED IN THIS CASE

On April 26, 2006, the Court of Common Pleas, Lehigh County granted Defendants' Motion for Summary Judgment in an unreported opinion. On May 3, 2007, the Commonwealth Court of Pennsylvania affirmed the Court of Common Pleas. 922 A.2d 1010; 2007 Pa. Commw. LEXIS 197 (Pa. Cmwlth. 2006). On January 30, 2008, the Supreme Court of Pennsylvania denied Petitioner's Petition for Allowance of Appeal at No. 442 MAL 2007, 2008 Pa. LEXIS 31 (Pa. January 30, 2008).

STATEMENT OF THE BASIS FOR THE JURISDICTION

The United States Supreme Court has jurisdiction over this matter pursuant to Supreme Court Rule 10(b). The Pennsylvania Supreme Court had jurisdiction over a Petition for Allowance of Appeal pursuant to 42 Pa.C.S.A. § 724(a) and Pa.Rule.App.Proc. 1112 as an appeal from a final order of the Commonwealth Court. The Commonwealth Court had jurisdiction over an appeal from the final order of the Court of Common Pleas of Lehigh County, Pennsylvania granting Summary Judgment in favor of Lehigh County and Warden Dale Meisel pursuant to 42 Pa.C.S.A. § 762.

CONSTITUTIONAL PROVISIONS, TREATIES, STATUTES, ORDINANCES, AND REGULATIONS INVOLVED IN THE CASE

42 U.S.C.§ 1983. Civil action for deprivation of rights

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.

Eighth Amendment to the United States Constitution

Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.

Fourteenth Amendment to the United States Constitution

Sec. 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

* * *

Sec. 5. The Congress shall have the power to enforce, by appropriate legislation, the provisions of this article.

STATEMENT OF THE CASE

1. In February of 2002 Enrique Veras was incarcerated and immediately placed on "suicide precaution" status. On February 11, 2002 Mr. Veras attempted suicide in his cell by hanging, and after spending six weeks in disciplinary segregation as punishment for the attempt, was returned to "suicide precaution" status on March 30, 2002 and remained on this status until he was released from Lehigh County Prison on April 2, 2002.

Enrique Veras returned to Lehigh County Prison on October 27, 2002, at which time he was placed on "suicide precaution" status, based on a medical assessment that stated "BE ABSOLUTELY WATCHFUL OF HIS BEHAVIOR. CONSIDER THIS PATIENT HIGH RISK FOR REPEATED SELF-INJURY. MUST HAVE SOMEONE WATCHING HIM AT ALL TIMES." [emphasis in original].

The next day, again while on suicide precautions, Mr. Veras fashioned a noose from bedding, and was found hanging from the cell bars. The nurse that responded opined "he's gone," but in fact Mr. Veras remained conscious and was placed in a "restraint chair." After two and a half hours, he was released from the restraint chair and remained on suicide precautions.

On November 4, 2002, Enrique Veras was transferred to the Mental Health Unit and remained

on "suicide precaution" status. Enrique Veras was removed from "suicide precaution" status on November 14, 2002, when he was transferred to disciplinary segregation as a result of his October 28 suicide attempt.

Mr. Veras was released from segregation on December 4, 2002, and began to engage in self-injurious behavior. Consequently, he was placed in a "suicide precaution cell", specifically Cell 3223 that is located in the Administrative/Disciplinary Segregation Unit. A Corrections officer in a booth in the unit is responsible for monitoring the inmate on suicide precautions, but the view is either partially or completing obscured by a staircase, depending on where the officer is standing in the booth.

Immediately upon being placed in the cell in 3C1, Mr. Veras began engaging in self-injurious behavior, including trying to hang himself by tying his underwear around his neck and to the towel bar in the cell. Mr. Veras was given a blanket and was stripped naked, and upon authorization from the medical department, was placed in a restraint chair between 8:45 P.M. and 9:00 P.M.. Between 10:30 P.M. and 10:45 P.M., correctional officers attempted to remove the Enrique Veras from the restraint chair, but he refused to leave the restraint chair, stating that he would harm himself if he were removed. He was therefore left in the restraint chair.

Mr. Veras remained on suicide precautions until the time of his death, sixteen hours later. On December 5, 2002 at approximately 4:10 P.M., Enrique Veras was found in Cell 3223 hanging in his

cell from the bars. The ligature was characterized as bed linen or a sheet. He was transferred to the hospital where he was pronounced dead.

2. Lehigh County Prison has a suicide prevention policy [Appendix 64-66] which states that the facility will "provide special housing, increased levels of observation, and medical restraint to those inmates who display self-destructive behavior." The Lehigh County Prison suicide prevention policy was based upon standards separately promulgated by the American Correctional Associate (ACA) and the National Commission on Correctional Health Care (NCCHC). The County has never contended that these standards are not applicable to them.

The ACA standard mandates constant observation for suicidal inmates. The NCCHC standards require that an inmate assessed as a high suicide risk be observed on a "continuing, uninterrupted basis or be transferred to an appropriate health facility." [Appendix p. 69, ¶ 5].

According to the references section of the Lehigh County Prison policy, a National Corrections Institute Publication was also consulted. That publication is a report prepared by Lindsay Hayes, Plaintiff's expert in this case. Director Sweeney reviewed Lindsay Hayes' publications in the process of issuing the Lehigh County Prison Suicide Prevention policy. The recommendations in that report echo the NCCHC requirements for continuous observation of actively suicidal inmates on a one-on-one basis, either by a member of the corrections staff or a fellow inmate.

The Lehigh County Prison policy does not require constant observation of inmates at high risk of suicide, nor does the policy on its face even provide for the possibility of constant observation. Director Sweeney, who considered the ACA and NCCHC standards when he issued the policy, had no explanation for why the standards for constant observation were omitted from the policy. He stated that there was no penological justification for omitting this.

3. The NCCHC standard requires that a cell designated for suicide prevention "be as nearly suicide-proof as possible (i.e. without protrusions of any kind that would enable the inmate to hang him/herself." However, Director Sweeney has admitted that the cells used as "suicide prevention" cells at Lehigh County Prison are not suicide resistant in that there are multiple ligature anchor points accessible to the inmate, and that he was aware of this deficiency.

The Lehigh County Prison policy provides for only two levels of observation for suicidal inmates: suicide precautions and close observation. The policy also provides for medical restraint (ie. the "restraint chair") as a temporary measure. The policy does not delineate any difference between the monitoring of inmates in the two levels, and the deposition testimony of all of the witnesses reveals that the only difference is whether the inmate is maintained clothed or stripped naked.

The suicide prevention cells at Lehigh County Prison all have open face bars, towel bars, and clothing hooks, all of which are easily recognizable ligature anchor points. Director Sweeney understood that the cells with open faced bars, including the one in which Mr. Veras committed suicide, are not safe for suicidal inmates in that the open bar cells provide multiple ligature points. Director Sweeney stated that an open bar cell is not suicide resistant, since "obviously . . . someone could certainly tie something to the door." Director Sweeney also understood that that there are no suicide resistant cells at the Lehigh County Prison.

4. The Federal questions sought to be reviewed were raised as integral parts of Petitioner's claims in their Complaint. [Appendix 97-106]. The questions were initially passed upon by the Court of First Instance, the Court of Common Pleas of Lehigh County, Pennsylvania, upon Respondents (Defendants below) Motion for Summary Judgment. That motion was denied. *See* Appendix p. 35-36. The issues were reconsidered by the Court of Common Pleas on Respondent's Motion, and were disposed by the Court's opinion. [Appendix 34-63]. The entirety of that opinion, except for those portions addressing matters of state civil procedure, is addressed to the issues for which review is sought. The matters were raised before the Commonwealth Court of Pennsylvania by Petitioner's appeal, and were addressed in the opinion of the Commonwealth Court. [Appendix 2-33]. The entirety of that opinion, except for those portions addressing matters of state civil procedure, is addressed to the issues for which review is sought. The questions were the subject of a

Petition for Allowance of Appeal [Appendix 107 *et seq.*] to the Pennsylvania Supreme Court, which was denied without opinion. [Appendix 1].

REASONS RELIED UPON FOR ALLOWANCE OF THE WRIT

1. This is a case that will permit the Supreme Court to discretely define the contours of the second part of the *Farmer* definition of "deliberate indifference," since the subjective knowledge of risk element was not at issue in the State Courts. Rather, the only question was what the Court should consider in determining whether the response was reasonable.

2. This Court has held that a prison official may be liable under 42 U.S.C. § 1983 if he was subjectively aware that an inmate faced a substantial risk of serious harm and disregarded that risk by failing to take reasonable measures to abate it. *Farmer v. Brennan*, 511 U.S. 825, 847 (1994). In this case, the record is clear that Enrique Veras faced a substantial risk of serious harm from suicide. Lehigh County conceded not only that Mr. Veras had a peculiar risk of suicide, but that the prison officials knew that he did. Under *Farmer*, the only remaining question was whether Lehigh County Prison failed to take reasonable measures to abate the risk to Mr. Veras.

3. Rather than follow the clear directions of this Court, the Court of Common Pleas, Commonwealth Court – and ultimately the Pennsylvania Supreme

Court, by denying allocatur – embarked upon two additional enquiries:

> *First*, whether the general record of suicides and suicide attempts at the Lehigh County Prison put the prison officials on notice of the need for different suicide precautions; and
>
> *Second*, whether the prison official subjectively appreciated that the suicide prevention policies posed a substantial risk of serious harm.

4. The first enquiry was improper because *Farmer* set up two distinct methods of proof as to whether there was a substantial risk of harm from suicide: one enquiry when the prison officials did not have actual notice of a peculiar risk to a particular inmate; and a separate enquiry where the prison officials had recognized that a particular inmate was at risk of suicide. The tests, while not mutually exclusive, are nonetheless separate and distinct, and a § 1983 Plaintiff need satisfy only one in order to prevail. In this case, Lehigh County Prison officials had recognized that Enrique Veras was at imminent risk of suicide, and had placed him on suicide precautions. At the time of his death by suicide, he had been on suicide precautions for approximately eighteen hours. There was no need to further enquire into whether there was a general risk at the prison.

5. The second enquiry was improper because the subjective appreciation standard in *Farmer* applies only to the initial question of whether the prison officials "drew the inference" that the inmate was at substantial risk, and not the second question of whether the prison officials took reasonable steps to abate the harm.

6. The record supported the conclusion that Lehigh County Prison knew that the provisions that it made for housing suicidal inmates was not proper, and therefore that the precautions were not reasonable. The lower courts erred in deciding the question of reasonableness as a matter of law, and also erred in completely disregarding the uncontested opinion of Plaintiff's expert, Lindsay Hayes, that the Lehigh County Prison procedures were contrary to prevailing correctional standards, and constitutionally infirm.

7. This Court has imposed § 1983 liability in a conditions of confinement case where the prison officials are "deliberately indifferent" to the inmates peculiar vulnerability to suicide. The controlling decision by this Court defines the standard as "a prison official may be held liable under the Eighth Amendment for denying humane conditions of confinement only if he knows that inmates face a substantial risk of serious harm and disregards that risk by failing to take reasonable measures to abate it." *Farmer v. Brennan*, 511 U.S. 825, 847 (1994).

In *Farmer*, this Court parsed the first requirement into two subparts,

> (1) the detainee had a particular vulnerability to suicide; and
>
> (2) the custodial officer or officers knew of that vulnerability

511 U.S. at 836 ("the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference"). The *Farmer* opinion equates the last factor with a breach of duty. 511 U.S. at 845 ("Whether one puts it in terms of duty or deliberate indifference, prison officials who act reasonably cannot be found liable under the Cruel and Unusual Punishments Clause.")

This Court explained that the term "deliberate indifference" lies "somewhere between the poles of negligence at one end and purpose or knowledge at the other." *Farmer*, 511 U.S. at 836. It is by this standard – and only this standard – that the Lower Courts were required to consider this case. The State Courts erred by misunderstanding that the holdings of pre-*Farmer* cases were still applicable.

8. In this case, Lehigh County Prison and Warden Meisel conceded that they had subjective knowledge that Enrique Veras was at substantial risk of death by suicide. Therefore, the only question was whether they took reasonable steps to abate the known risk.

9. The State Courts did not recognize that there is both an objective and a subjective component to a deliberate indifference claim – Did the prison

official have *subjective* knowledge of a peculiar or general risk; and were the measure taken to abate the risk *objectively* reasonable. *Farmer*, 511 U.S. at 846 ("to survive summary judgment, he must come forward with evidence from which it can be inferred that the defendant-officials were at the time suit was filed, and are at the time of summary judgment, knowingly and unreasonably disregarding an objectively intolerable risk of harm"); *See also Montgomery v. Pinchak*, 294 F.3rd 492, 499 (3rd Cir. 2002).

The only question at issue in this case was the second question: whether the Lehigh County Prison failed to take objectively reasonable steps to abate the danger to Enrique Veras. *Farmer*, 511 U.S. at 847 ("a prison official may be held liable under the Eighth Amendment for denying humane conditions of confinement only if he knows that inmates face a substantial risk of serious harm and disregards that risk by failing to take reasonable measures to abate it.") The factor that defines where an act or omission falls on the continuum between negligence and intent is where the prison official subjectively perceives that an inmate is at risk. Once that degree of knowledge is achieved, the prison is bound to provide an objectively reasonable abatement.

10. The State Courts placed great emphasis on the lack of a significant history of prior suicides at the Lehigh County Prison. [Appendix 10-11, 23-24] Under *Farmer*, the record of prior suicides and suicide attempts may be relevant to the subjective knowledge enquiry, but only if there was no evidence of subjective knowledge of a particular vulnerability

to suicide of the inmate in question. *Farmer*, 511 U.S. at 842-43. Since there is no question that the prison and its top officials had actual knowledge of Mr. Veras' particular vulnerability, the prior record (or lack thereof) of suicide attempts is not a proper consideration. Even if this was a proper consideration, that consideration would be for the fact-finder in determining the reasonableness of the response, and not for the Court.

11. The Commonwealth Court also erred in requiring proof of *scienter*. [Appendix p. 23]. In so holding, the Commonwealth Court mistakenly relied upon the opinion of the Court of Appeals for the Third Circuit in *Simmons v. City of Philadelphia*, 947 F.2d 1042, 1060-1061, n. 13 (3rd Cir. 1991). However, this Court repudiated such a requirement in *Farmer*. The standard of purposeful or knowing conduct is not necessary to satisfy the requirement of deliberate indifference. *Id.* at 836. This Court further clarified that it did not intend to require a plaintiff to show intent to harm on the part of the prison, nor did it require direct evidence of the prison's knowledge of the vulnerability. *Farmer*, 511 U.S. at 842. Nor must an Eighth Amendment claimant show that a prison official acted or failed to act believing that harm actually would befall an inmate; it is enough that the official acted or failed to act despite his knowledge of a substantial risk of serious harm. *Id.*.

12. The State Courts also held that the prison was effectively immunized from liability by delegating decisions on housing assignments to its contracted medical provider, based upon *Spruill v. Gillis*, 372 F.3rd 218 (3rd Cir. 2004). [Appendix p. 56-

57]. In *Spruill*, the Court of Appeals held that non-medical prison staff may rely on the medical treatment being given by the medical staff. However, the issue in *Spruill* was whether an inmate was receiving proper medical care for an injury, not whether the prison had proper housing facilities and inmate monitoring policies. Neither the facts in that case, nor the Court's decision, suggest application of this rule to any security or housing issues.[1]

This standard should be inapplicable to a claim relating to conditions of confinement. Mr. Veras clearly suffered from a serious medical condition, and was being treated by prison medical

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[1] Indeed, the cases that have relied upon the substantive issue of the *Spruill* case, namely the liability of prison officials for medical decisions (as opposed to the administrative exhaustion issue), have been cases where a dispute has arisen over the quality of medical treatment for discrete illness or injury, and not conditions of confinement. *See* e.g. *Anderson v. Bureau of Prisons*, 2006 U.S. App. LEXIS 9034 (3d Cir. 2006)(defendants misdiagnosed his knee and back pain and provided "conservative" treatments that were ineffective); *Wall v. Dauphin County*, 2006 U.S. App. LEXIS 3732 (3rd Cir. 2006)(licensed nurse began treating inmate as soon as he collapsed); *Brooks v. Beard*, 2006 U.S. App. LEXIS 3494 (3d Cir. 2006)(medical decisions regarding follow-up visits to the specialist and physical therapy); *Catchings v. Marrow*, 160 Fed. Appx. 256, 258 (3rd Cir. 2005)(prescription decision); *Thomas v. Dragovich*, 142 Fed. Appx. 33, 37 (3rd Cir. 2005)(prison knew that medical department had denied treatment yet "failed to help"); *Jones v. Falor*, 135 Fed. Appx. 554, 555 (3rd Cir. 2005)(adequate course of medical treatment for a left knee injury); *Vile v. Klem*, 131 Fed. Appx. 386, 388 (3rd Cir. 2005)(injuries sustained during surgical procedure); *Ali v. Terhune*, 113 Fed. Appx. 431, 434 (3d Cir. 2004)(medical staff also chose simply to administer generic pain relievers, rather than send Plaintiff for a surgical procedure).

staff. However, that staff did not make any recommendations, nor issue any orders with respect to the conditions under which Mr. Veras would be housed. Lehigh County Prison conceded that it does not routinely provide constant observation, but argues that it will be provided if there is a specific medical order. Lehigh County Prison also contended that the medical contractor's policies supplement the Lehigh County Prison policies.

However, the contractor's policy assumed that constant observation will be provided to inmates on suicide precautions. That policy states that potentially suicidal inmates will be "placed in area designated by security to permit close observation." [emphasis added]. [Appendix 75, ¶ 5(b)]. The NCCHC standards define "close observation" as constant observation. [Appendix 69, ¶ 5]. Lehigh County Prison has no official policy delegating any housing questions to the contractor, and no official policy that provides for constant observation under any circumstances. [Appendix 64-66]. The allocation of the burden for setting housing conditions on the medical contractor has been identified by Plaintiffs' expert as a willful indifference to the suicidal inmate.

13. The State Courts impermissibly linked municipal liability under Section 1983 to proof that a municipal actor is liable for a constitutional tort. In this case, the Commonwealth Court engaged in an extensive analysis of the liability of Warden Meisel, [Appendix p. 17-27], ultimately holding that Warden Meisel was not liable under §1983. The Court then disposed of the claim against Lehigh County, holding that

> This Court has expressly adopted the *Trigalet* analysis. ("We hold, therefore, that in the absence of an underlying unconstitutional action by employees of the City . . ., we will not consider the question of whether the City [has liability] . . ."); (accepting the "reasoning of the vast majority of federal circuits, which adopt the general rule that a municipality cannot be liable unless there is a constitutional violation by the municipal actor causing the plaintiff's harm"). [Internal citations omitted]

[Appendix p. 29-30].

The Commonwealth Court recited the *"Trigalet"* analysis (from *Trigalet v. City of Tulsa*, 239 F.3d 1150, 1155 (10th Cir. 2002) as

> a municipality cannot be held liable in a *Section 1983* action in the absence of a predicate unconstitutional act by the municipality's employee. Even if the municipality's actions are arbitrary or even "conscience shocking, in a constitutional sense" the municipality cannot be held liable under § 1983. This is because a claim of "inadequate training [or] supervision . . . under §1983 cannot be made out against a supervisory authority absent a finding of a constitutional violation by the

> person supervised." [Internal citations omitted].

Id.

This is an accurate statement of the law, as the Third Circuit recognized in *Brown v. Pa. Dep't of Health Emergency Med. Servs. Training Inst.*, 318 F.3rd 473, 482-483 (3rd Cir. 2003), but the Pennsylvania Courts did not apply this rule properly. A municipality may be held independently liable for a substantive due process violation even in situations where none of its employees are liable, but have nonetheless violated plaintiff's constitutional rights, *Collins v. City of Harker Heights*, 503 U.S. 115, 122, (1992) (emphasizing "the separate character of the inquiry into the question of municipal responsibility and the question whether a constitutional violation occurred."). Indeed, in *Farmer*, 511 U.S. at 841 this Court held that allegations that individual officers violated Eighth Amendment rights are examined using a *subjective* awareness standard while allegations of municipal misconduct receive an *objective* analysis).

14. "[I]t is when execution of a government's policy or custom . . . inflicts the injury that the government as an entity is responsible under § 1983." *Monell v. Department of Soc. Servs.*, 436 U.S. 658, 694, (1978). There is municipal liability for a policy or practice that is the "direct cause" or "moving force" behind the constitutional violation. *See City of Oklahoma v. Tuttle*, 471 U.S. 808, 820 (1985); *City of Canton*, 489 U.S. at 385; *Monell*, 436 U.S. at 691. A constitutional injury caused by a municipality may

be shown directly by demonstrating that the policy itself is unconstitutional. *See id.* at 694-95 (holding that a municipality may be liable under § 1983 for a policy that requires pregnant women to take unpaid leave before leave was required for medical reasons because the policy itself is unconstitutional).[2]

15. The State Courts misapplied the decision of this Court in *Bell v. Wolfish*, 441 U.S. 520 (1979), essentially as a *per se* rule against the consideration of evidence of prevailing industry standards. [Appendix 20; 62 n.15]. This Court has recently disapproved such *per se* rules in *Fed. Express Corp. v. Holowecki*, ___ U.S. ___, 28 S. Ct. 1147, 170 L. Ed. 2d 10 (2008).

Plaintiff offered the expert opinion of Mr. Lindsay Hayes, perhaps one of the foremost experts in the United States in the field of Prison suicide prevention. [Appendix 76-96]. Hayes was highly critical of the Lehigh County suicide prevention policy on the basis of a lack of continuous visibility of the "suicide prevention" cell, the availability of ligature anchor points, including the open cell bars, and absence of the option of continuous observation. Mr. Hayes deemed these conditions "one the worst cases [he had] reviewed in the past 25 years" from the perspective of suicide prevention. The Pennsylvania Courts refused to consider this opinion

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[2] Petitioner does not argue, as the Commonwealth Court mistakenly believed, that a municipality has *Monell* liability in the absence of a constitutional violation, as the Third Circuit once held in *Fagan v. City of Vineland*, 1993 U.S. App. LEXIS 20327 (3rd Cir. 1993), *aff'd* 22 F.3rd 1296 (3rd Cir. 1994)(*en banc*). This was clearly repudiated in *Brown*.

since it was derived by reference to prevailing published standards.

In *Bell*, this Court held that published standards for prison conditions, while not determinative of constitutional requirements, may be instructive as the accepted standards for prison conditions. 441 U.S. at 543 n. 27. While NCCHC and ACA standards are not binding standards, they are certainly evidence of what are reasonable steps to abate the risk of suicide. *Id.*; *Gates v. Cook*, 376 F.3rd 323 (5th Cir. 2004) (ACA accreditation and compliance with standards are relevant considerations but not dispositive of compliance with the Eighth Amendment).

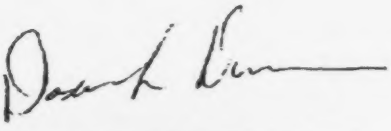
In fact, the Lehigh County Prison suicide prevention policy is based upon both sets of standards, but follows neither. The prison was not able to explain its decision not to follow the standards. This raises a clear question of whether the decision – the product of deliberation – was reasonable. An unreasonable decision which is the product of deliberation is "deliberate indifference." *Pembaur v. City of Cincinnati*, 475 U.S. 469, 483-84 (1986)("municipal liability under § 1983 attaches where a deliberate choice to follow a course of action is made from among various alternatives by the official or officials responsible for establishing final policy with respect to the subject matter in question.")

CONCLUSION

The Court of Common Pleas once recognized that this is not a case which is clear and free from doubt as to whether the Lehigh County Prison and Warden Meisel acted reasonably in response to a known risk of serious injury. This was the correct decision. Thereafter, this case took a tortuous route, made even more convoluted by the errors discussed herein. This Petition for Writ of Certiorari requests that the Supreme Court correct the errors of law perpetuated by the State Courts, and clarify the standard to be applied in the second prong of the *Farmer* definition in the interest of all future inmates who are threatened by suicidal ideation.

Respectfully submitted,

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Dated: April 25, 2008

RUTH AROCHO, AS ADMINISTRATRIX OF THE ESTATE OF ENRIQUE RENE VERAS AND WADAYS VERAS AND RUTH AROCHO AS PARENT AND GUARDIAN OF CRYSTAL VERAS AND YASHERA VERAS, Petitioners v. COUNTY OF LEHIGH AND DALE MEISEL, Respondents

No. 442 MAL 2007

SUPREME COURT OF PENNSYLVANIA

2008 Pa. LEXIS 31

January 30, 2008, Decided

NOTICE: DECISION WITHOUT PUBLISHED OPINION

PRIOR HISTORY: [*1]
Petition for Allowance of Appeal from the Order of the Commonwealth Court.
Arocho v. County of Lehigh, 922 A.2d 1010, 2007 Pa. Commw. LEXIS 197 (Pa. Commw. Ct., 2007)

ORDER

PER CURIAM

AND NOW, this 30th day of January, 2008, the Petition for Allowance of Appeal is **DENIED**.

LEXSEE

Ruth Arocho, As Administratrix of the Estate of Enrique Rene Veras and Wadays Veras and Ruth Arocho as Parent and Guardian of Crystal Veras and Yashera Veras, Appellants v. County of Lehigh and Dale Meisel

No. 1008 C.D. 2006

COMMONWEALTH COURT OF PENNSYLVANIA

2007 Pa. Commw. LEXIS 197

December 13, 2006, Argued
May 3, 2007, Decided
May 3, 2007, Filed

PRIOR HISTORY: [*1] Appealed from No. 2003-C-3235. Common Pleas Court of the County of Lehigh. Judge Brenner, J.

DISPOSITION: AFFIRMED.

COUNSEL: David L. Deratzian, Bethlehem, for appellants.

Rudolph Zieger, Allentown, for appellees.

JUDGES: BEFORE: HONORABLE JAMES GARDNER COLINS, President Judge, HONORABLE BERNARD L. McGINLEY, Judge, HONORABLE

DAN PELLEGRINI, Judge, HONORABLE BONNIE BRIGANCE LEADBETTER, Judge, HONORABLE RENEE COHN JUBELIRER, Judge, HONORABLE ROBERT SIMPSON, Judge, HONORABLE MARY HANNAH LEAVITT, Judge. OPINION BY JUDGE LEAVITT.

OPINION BY: MARY HANNAH LEAVITT

OPINION: OPINION
BY JUDGE LEAVITT

The children and estate (Estate) of Enrique Veras (Decedent), n1 who committed suicide while incarcerated at the Lehigh County Prison (Prison) on December 5, 2002, appeal a judgment of the Court of Common Pleas of Lehigh County (trial court). By this judgment, the trial court held that the Estate could not sustain its *42 U.S.C. § 1983* action for damages against Dale Meisel, the Prison Warden, or against Lehigh County for their alleged violations of Decedent's constitutional rights. In this case we consider whether the trial court erred by holding, as a matter of law, that neither Meisel nor Lehigh **[*2]** County acted with "deliberate indifference" to Decedent's particular vulnerability to suicide while he was incarcerated in the Prison.

n1 Appellant Ruth Arocho is the administratrix of Decedent's estate and the mother of Decedent's minor children, Crystal Veras and Yashera Veras. Appellant Wadays Veras is Decedent's adult child.

Suicide Prevention Policy

Because it is central to the outcome of this case, we begin with an overview of the Prison's Suicide Prevention Policy (Policy), which became effective on April 20, 2001. The stated purpose of the Policy is "[t]o provide written procedures regarding Lehigh County Prison's suicide prevention program in order to protect inmates from self-harm or death." Reproduced Record at 59a (R.R.). The Policy is also designed to "provide special housing, increased levels of observation, and medical restraint to those inmates who display self-destructive behavior." *Id.* All inmates are evaluated, and any inmate identified as a potential suicide risk is [*3] further evaluated by a nurse or psychiatrist. If the evaluator determines that the inmate requires an increased level of care, then the inmate can be placed on one of three levels of increased observation: "close observation," "suicide precaution" or "medical restraints." R.R. 60a-61a.

The minimum level of observation is "close observation" status. Close observation includes a periodic check on an inmate's behavior. Observations are documented by the Housing Unit Officer on a Psychiatric Check Report, which is submitted to the Medical Department n2 at the end of each shift. Medical staff review the check reports each shift for any significant changes in behavior.

n2 "Medical Department" refers to Wexford Health Sources, which is the independent medical provider at the Prison. Wexford Health Sources is not a party to this action.

"Suicide precaution" status is the intermediate level of observation under the Policy. An inmate on

suicide precaution is housed in an open-barred cell clothed only in a blanket, and [*4] is periodically checked by a guard. Specifically, the Policy sets the following monitoring and housing requirements for an inmate on suicide precaution status:

a) The Housing Unit Officer shall issue a heavy blanket in good structural condition to the inmate.

b) The Nurse shall place the inmate on Finger Foods/No Utensil status.

c) The Housing Unit Officer shall offer a daily shower to the inmate and directly supervise the inmate showering.

d) The Housing Unit Officer shall monitor the inmate at irregular fifteen-minute intervals (no more than fifteen minutes between checks). The checks are staggered so that there is no predictable pattern for the inmate to use in planning suicide.

e) The Housing Unit Officer shall document suicide checks on the psychiatric check form and submit it to the medical department at the end of each shift.

f) Medical staff will review the check report each shift for any significant changes in behavior.

g) Medical staff will have daily contact with the inmate.

h) In the event of an official visitor (i.e. attorney, parole official) the inmate will be dressed and escorted

to the appropriate visit area and remain under [*5] direct visual observation by the escorting officer.

R.R. 60a.

The Policy's most restrictive level of observation requires physical restraint when ordered by a physician. An inmate who exhibits extreme behavior potentially or actually harmful to himself or to others may be placed in a restraint chair. The use of "medical restraints" is subject to the following conditions in the Policy:

a) The [restraint chair] is the only approved form of medical restraint.

b) Staff supervising the placing of an inmate into the Restraint Chair must be trained in its use.

c) Medical personnel must check the initial application of restraints to ensure circulation is not impaired.

d) The inmate will be dressed in clothing appropriate to temperature unless otherwise specified by the mental health order.

e) Medical staff shall make an assessment every two hours of the inmate's behavior, position, restraints, and health care needs (food, water, elimination and cleanliness) and ensure the needs are met.

f) The Housing Unit Officer shall monitor the inmate at irregular fifteen-minute intervals (no more than fifteen minutes between checks).

g) The Housing Unit [*6] Officer shall document medical restraint checks on a Psychiatric Check Report Form and submit them to the Medical Department at the end of each shift.

h) Medical staff will review the check report each shift for any significant changes in behavior.

i) The Housing Unit Officer shall document each time the inmate is released from medical restraints, or the reason for not releasing the restraints.

j) Medical restraint orders shall not exceed 24 hours.

k) Medical restraints shall not be removed without a physician's order with the following exception. The Housing Unit Officer shall remove the restraints every two hours for ten minutes unless the inmate is extremely agitated. The inmate must be monitored continuously when out of medical restraints.

R.R. 61a.

Dale Meisel began working at the Prison in 1989 and became warden in February 2002. He would later testify by deposition that he had no specific recollection of writing the Policy that was in place at the time of Decedent's suicide. Meisel Deposition, August 29, 2005, at 44 (Meisel Depo.). Meisel acknowledged, however, that as warden he is responsible for promulgating all policies for [*7] the prison, which

are then co-signed by the Director of Corrections for Lehigh County, in this case Edward Sweeney. *Id.* at 50. n3 Meisel is also responsible for training correctional officers and for enforcing all Prison policies.

n3 The Policy at issue in this case was signed by Edward Sweeney on April 20, 2001. Sweeney was not named as a defendant in the Estate's *Section 1983* action.

In their depositions, Meisel and Sweeney acknowledged that the open-barred cell used to house suicidal inmates has points that can be used by a suicidal inmate to hang himself. Nevertheless, they did not believe a solid plastic wall was preferable. The inmate could scratch the wall until it was opaque and difficult to see through. In addition, a solid wall would impede the ability of guards to hear what an inmate was doing. Meisel Depo. 84-85, 114-115; Sweeney Deposition, September 8, 2005, at 54, 101 (Sweeney Depo.); Supplemental Reproduced Record at 14b-15b; 25b-26b; 35b; 49b (S.R.R. [*8]).

Decedent's Incarceration and Suicide

Decedent's first period of incarceration was from February 2002 until April 2002. Upon his incarceration Decedent was immediately placed on suicide precaution status. Decedent attempted to hang himself with a makeshift rope on February 11, 2002, and remained on suicide precaution status until February 21, 2002, when he was downgraded to close observation status. Decedent was removed from close observation status on February 25, 2002. He was returned to suicide precaution status on March 30,

2002, and remained on that status until he was released from the Prison on April 2, 2002.

Decedent returned to Prison on October 27, 2002, and was placed on suicide precaution status. After he engaged in self-injurious behavior, he was placed in a restraint chair with the authorization of the Medical Department and remained on suicide precaution status. On October 28, 2002, Decedent attempted to hang himself by tying a strip of blanket around his neck and attaching it to the cell bars. He was again placed in a restraint chair. On November 4, 2002, Decedent was transferred to the Mental Health Unit where he remained on suicide precaution status until [*9] November 14, 2002.

On December 4, 2002, Decedent became enraged upon learning he was being switched to a different cell in the Mental Health Unit and began engaging in self-injurious behavior. He was placed in a "suicide precaution cell," specifically Cell 3223, in the Administrative Segregation/Disciplinary Segregation Unit. n4 A cell is designated a "suicide precaution cell" based upon the recommendations of both custody staff and treatment staff; must be subject to the best available sight line from the control booth; and must be an "open bar" cell. Meisel Depo. 71; R.R. 125a. After he was placed in Cell 3223, Decedent attempted to hang himself by tying his underwear to a towel bar. Accordingly, the Medical Department directed officers to remove Decedent's clothing, gave him a blanket and placed him in a restraint chair from 8:45 p.m. to 9:00 p.m. Officers attempted to remove Decedent from the chair between 10:30 p.m. and 10:45 p.m., but Decedent refused and stated that he would harm himself. The Medical Department placed Decedent on suicide precaution status at 11:18 p.m. Dece-

dent was removed from the restraint chair at 12:30 a.m. on December 5, 2002, and a mattress, after first [*10] being examined by an officer, was placed in Cell 3223. Officers checked Decedent every 30 minutes from 12:00 a.m. to 7:30 a.m., and thereafter every 15 minutes until 4:00 p.m. At 4:10 p.m. Decedent was found standing with his back to the cell door and with a piece of bed linen tied around his neck and attached to the cell door. Decedent was transferred to the hospital and pronounced dead at 4:54 p.m.

n4 There are three correctional officers assigned to the Administrative Segregation/Disciplinary Segregation Unit, in contrast to other units of the Prison where only one correctional officer is assigned. One of the three officers is assigned to the control booth and the other two officers are responsible for walking the pod. The correctional officer in the booth is responsible for monitoring an inmate who, pursuant to the Policy, requires observation. All three of the correctional officers are responsible for observing a potentially suicidal inmate. *See* Meisel Depo. 76-77; Sweeney Depo. 66-67. If the officer assigned to the booth cannot observe the inmate, one of the other correctional officers on the pod is required to go to the cell and check on the inmate.

[*11]

Prior Incidents

According to Meisel and Sweeney, approximately 6,500 inmates pass through the Prison every year. Meisel Depo. 94; Sweeney Depo. 107. The Estate's evidence confirmed this figure. S.R.R. 172b-173b.

Three inmates have committed suicide since the Prison opened in 1992. Meisel Depo. 32, 42. The first successful suicide was in 1995, when an inmate took his own life by hanging. S.R.R. 159b. Decedent's suicide was the second. The third incident occurred in 2003 or 2004, after Decedent's suicide. Meisel Depo. 42. Additionally, the Estate's evidence showed that between February 7, 2000, and October 28, 2002, there were five suicide attempts, including Decedent's first attempt to hang himself. S.R.R. 159b-169b.

Procedural History

The Estate filed a civil action under *42 U.S.C. § 1983* against Meisel and Lehigh County on December 10, 2004, alleging, *inter alia*, that "the policies and practices of the County of Lehigh were the direct and proximate cause of the constitutional harm caused to [Decedent]." Complaint, P12. n5 The Estate sought compensatory damages from Meisel, in his supervisory capacity as Warden, and from Lehigh County under **[*12]** a theory of municipal liability. The Estate also requested that the trial court declare the Policy unlawful and enjoin its continued use. Meisel and Lehigh County moved for summary judgment, which the trial court initially denied on January 3, 2006. Upon reconsideration, the trial court heard oral argument and granted summary judgment in favor of Meisel and Lehigh County on April 26, 2006. The Estate now appeals the trial court's order.

n5 The complaint pled wrongful death and survivor actions under *42 Pa. C.S. §§ 8301-8302*, as well as violations of the *First, Fourth, Fifth, Eighth* and *Fourteenth Amendment to the United States Consti-*

tution and *Article I, Section 8 of the Pennsylvania Constitution*. By the time the judgment in favor of Meisel and Lehigh County was entered, only the *Eighth* and *Fourteenth Amendment* claims remained in litigation.

On appeal, n6 the Estate argues that the trial court erred in granting summary judgment to Meisel and Lehigh County. The Estate argues that its evidence, an expert report, [*13] raised a factual question of whether the procedures in effect at the prison were "constitutionally infirm." Estate's Brief at 3. Thus, the question of whether Meisel and Lehigh County responded with "deliberate indifference" to Decedent's vulnerability to suicide must be decided by a jury. The Estate also contends that the trial court impermissibly relied upon oral deposition testimony in granting summary judgment. *Borough of Nanty-Glo v. American Surety Co. of New York, 309 Pa. 236, 163 A. 523 (1932)*. We consider these questions *seriatim*.

n6 In reviewing a trial court's order granting summary judgment, "[a]n appellate court may disturb the order of the trial court only where there has been an error of law or a manifest abuse of discretion. Notwithstanding, the scope of review is plenary and the appellate court shall apply the same standard for summary judgment as the trial court." *Cooper v. Delaware Valley Medical Center, 539 Pa. 620, 632, 654 A.2d 547, 553 (1995)*. Summary judgment may be granted if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue of material fact and that the moving

party is entitled to a judgment as a matter of law. *Pa. R.C.P. No. 1035.2; Limbach Co., LLC v. City of Philadelphia, 905 A.2d 567, 572 (Pa. Cmwlth. 2006).* The record must be viewed in the light most favorable to the opposing party, and all doubts as to the existence of a genuine issue of material fact must be resolved against the moving party. *Id. at 573.* Summary judgment is proper only when the facts are so clear that reasonable minds cannot differ. *Id.*

[*14]

***Eighth Amendment* Prison Standards**

The gravamen of the Estate's action is that Meisel and Lehigh County subjected Decedent to cruel and unusual punishment in violation of the *Eighth Amendment to the United States Constitution*, made applicable to the states by the *Fourteenth Amendment.* n7 *Estelle v. Gamble, 429 U.S. 97, 101, 97 S. Ct. 285, 50 L. Ed. 2d 251 (1976).* The prohibition against cruel and unusual punishment is broad enough to proscribe "deliberate indifference to serious medical needs of prisoners [that] constitutes the 'unnecessary and wanton infliction of pain.'" *Id. at 104* (citation omitted). Accordingly, "deliberate indifference to a prisoner's serious illness or injury states a cause of action under [*42 U.S.C. §] 1983.*" *Id. at 105.*

n7 The *Eighth Amendment* provides: "Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted." *U.S.Const. amend. VIII.* The *Fourteenth Amendment* provides, in pertinent part: "No State shall make or enforce any law which shall abridge the privileges or

immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws." *U.S. Const. amend. XIV, § 1.*

[*15]

A serious medical need can include a psychiatric one. In *Colburn v. Upper Darby Township, 838 F.2d 663 (3d Cir. 1988) (Colburn I)*, it was held that an inmate's "particular vulnerability to suicide" represents a "serious medical need" as that term was defined in *Estelle.* Subsequently, the Third Circuit articulated a standard for prison suicide cases as follows:

[A] plaintiff in a prison suicide case has the burden of establishing three elements: (1) the detainee had a "particular vulnerability to suicide," (2) the custodial officer or officers knew or should have known of that vulnerability, and (3) those officers "acted with reckless indifference" to the detainee's particular vulnerability.

Colburn v. Upper Darby Township, 946 F.2d 1017, 1023 (3d Cir. 1991) (Colburn II). The *Colburn II* court explained that the terms "reckless indifference" and "deliberate indifference" are interchangeable. *Id. at 1024.* It declined to precisely define "deliberate indifference," but noted that "a level of culpability higher than a negligent failure to protect from self-inflicted harm is required and that this requirement

[*16] is relevant to an evaluation of the first two ... elements as well as the third." *Id.*

Three years after *Colburn II* was decided, the United States Supreme Court offered its first articulation of "deliberate indifference" for purposes of its *Eighth Amendment* jurisprudence. In *Farmer v. Brennan, 511 U.S. 825, 114 S. Ct. 1970, 128 L. Ed. 2d 811 (1994)*, n8 the Supreme Court rejected an objective test for deliberate indifference, such as that adopted by the Third Circuit in *Coburn II*. Instead, the Court borrowed the concept of subjective recklessness from criminal law and held that

a prison official cannot be found liable under the *Eighth Amendment* for denying an inmate humane conditions of confinement unless the official *knows of and disregards an excessive risk to inmate health or safety; the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference.* ...

Id. at 837 (emphasis added). n9 The Court explained further that "prison officials who actually knew of a substantial risk to inmate health or safety may be found free from liability [*17] if they responded reasonably to the risk, even if the harm ultimately was not averted." *Id. at 844.*

n8 *Farmer* was not a *Section 1983* action but, rather, a *Bivens*-type suit brought by an inmate in a federal prison against federal prison officials. Nevertheless, it is the last word on what the *Eighth*

Amendment requires with respect to prison health and safety. Further, *Farmer* did not concern a prison suicide but, rather, the violent assault of a transsexual inmate by other inmates. It was alleged that the federal prison officials acted with deliberate indifference when they placed a transsexual inmate in the general prison population, thereby failing to protect him from attacks of other inmates.

n9 The Estate contends, and the trial court agreed, that *Farmer* effectively eliminated the objective "should have known" language from the second prong of the *Colburn II* standard. Notably, the Third Circuit continues to evaluate the liability of prison officials in prison suicide cases in accordance with the *Colburn II* standard, including whether the official "knew or should have known" of an inmate's particular vulnerability to suicide. *See, e.g., Woloszyn v. County of Lawrence, 396 F.3d 314 (3d Cir. 2005).* This Court is not bound by the Third Circuit's interpretation of the *Eighth Amendment* but only by our Supreme Court's interpretations and those of the United States Supreme Court. *See Thomas v. City of Philadelphia, 804 A.2d 97, 111 n. 29 (Pa. Cmwlth. 2002).*

[*18]

In establishing a subjective test, the Supreme Court drew on precedent holding that the constitutional deprivation had to be obvious and that the prison official must have "a sufficiently culpable state of mind." *Id. at 834.* Further, that state of mind must be "more blameworthy than negligence." *Id. at 835.* In rejecting the objective test for deliberate indifference, the Supreme Court explained as follows:

[A]n official's *failure to alleviate a significant risk that he should have perceived but did not,* while no cause for commendation, cannot under our cases be condemned as the infliction of punishment.

Id. at 838 (emphasis added). Therefore, an official who is not aware of a substantial risk cannot be held liable under the *Eighth Amendment.* Nevertheless, the Supreme Court allowed that the fact finder might find the existence of subjective knowledge on the part of a prison official if it could be shown that inmates had suffered numerous injuries in the prison. *Id. at 842. See also Beers-Capitol v. Whetzel, 256 F.3d 120, 133 (3d Cir. 2001)* ("[S]ubjective knowledge on the part of the official can be proved by circumstantial [*19] evidence to the effect that the excessive risk was so obvious that the official must have known of the risk.").

Liability of Meisel

The Estate did not sue any custodial officer or medical personnel who dealt with Decedent at the Prison. The trial court found that Meisel had no direct involvement with Decedent and, thus, "Meisel did not act with reckless indifference with respect to [D]ecedent's suicidal ideations and attempts to kill himself." Trial Court Opinion at 8. The only question was whether Meisel had liability for his actions as a supervisor, particularly with respect to the adoption of the Policy. The trial court found that Meisel could not be held liable, and we agree.

The gravamen of the Estate's claim is that the Policy, for which Meisel bears at least some responsibility, was "deliberately indifferent" to the Decedent's known vulnerability to suicide and therefore unconstitutional. n10 The Estate argues that Meisel considered nationally accepted suicide prevention standards promulgated by the American Correctional Association (ACA) and the National Commission on Correctional Health Care (NCCHC), n11 but he did not incorporate them into the Policy. The result, **[*20]** the Estate claims, was a Policy deliberately indifferent to the needs of those inmates, including Decedent, with a vulnerability to suicide. The Estate identifies two ways in which the Policy's deviations from the ACA and NCCHC's standards made the Policy constitutionally infirm.

n10 The Estate essentially conceded at oral argument that its case hinges on the constitutionality of the Policy itself.

n11 The Policy specifically references the ACA and NCCHC standards, and Sweeney acknowledged that the standards were considered in formulating the Policy. Sweeney Depo. 44. To support their deliberate indifference claim, Appellants relied on the ACA and NCCHC standards as well as a report authored by their expert, Lindsay M. Hayes, who opined, based on the standards, that the Policy was constitutionally infirm. Hayes is a project director at the National Center on Institutions and Alternatives and a nationally recognized expert in the field of suicide prevention in correctional facilities.

First, the Estate [*21] objects to the Policy because it does not require, or even provide for, "constant observation" of suicidal inmates. By contrast, the NCCHC standards suggest that "[a]n inmate assessed as being a high suicide risk always should be observed on a continuing, uninterrupted basis or transferred to an appropriate health care facility." R.R. 73a. Although constant observation is, and has been, provided to Prison inmates when ordered by medical staff, the Estate rejoins that this is insufficient. The NCCHC standards require constant observation of a suicidal inmate, with or without a medical order. If Decedent had been under constant observation, even by a fellow inmate, the Estate believes he would not have been able to hang himself.

Second, the Estate complains that the Prison's "suicide precaution cells," required under the Policy, are not suicide-resistant because they have open bars and other ligature points, such as towel bars. The NCCHC recommends that a suicidal inmate's cell "should be as nearly suicide-proof as possible (i.e., without protrusions of any kind that would enable the inmate to hang him/herself)." R.R. 73a. The Estate argues that covering the cell bars with a clear [*22] material is a more effective way to make a cell suicide-resistant.

The Estate's reliance on the ACA and NCCHC standards as the baseline against which to measure the constitutionality of the Policy is misplaced. Those standards represent the recommendations of private organizations in the corrections field that provide accreditation services to correctional facilities. They were not intended to be constitutional mandates, nor could they be since they have not been adopted by any governmental entity. The failure of a correc-

tional facility to comply with these standards means only that it will not be accredited by ACA or NCCHC.

Moreover, the United States Supreme Court has held, in the context of a prison conditions case, that correctional standards issued by organizations like ACA and NCCHC, and even by the Department of Justice, may be instructive in certain cases but "do not establish the constitutional minima; rather, they establish goals recommended by the organization in question." *Bell v. Wolfish, 441 U.S. 520, 543 n. 27, 99 S. Ct. 1861, 60 L. Ed. 2d 447 (1979).* Meisel explained, for example, why cells with clear, solid walls, as recommended by the ACA and NCCHC, were not preferable [*23] to the open-barred holding cells in the Prison used to house suicidal inmates. Even if Meisel were wrong in his judgment, this does not demonstrate deliberate indifference but, at most, negligence. Deliberate indifference "describes a state of mind more blameworthy than negligence." *Farmer, 511 U.S. at 835.*

Other cases involving a challenge to the constitutionality of a prison's suicide prevention policy illustrate the Estate's very high burden in this case. For example, in *Litz v. City of Allentown, 896 F. Supp. 1401 (E.D. Pa. 1995),* the plaintiff's ward, Bobby F. Chain, Jr., attempted to commit suicide while in a holding cell at the Allentown Police Department. Department policies required officers to remove prisoners' belts, excess clothing, shoelaces and personal effects. In addition, video cameras were installed in the cells and officers were required to observe prisoners every 30 minutes, or every 15 minutes if the prisoner was suicidal. Despite these measures, Chain attempted to hang himself with his socks and suffered brain damage. Plaintiff initiated a *Section 1983* ac-

tion against the City of Allentown, the Chief of Police and several other [*24] officers in their official capacities. Plaintiff argued, *inter alia*, that certain proposed department policies, which were rejected, would have prevented the incident. These included installing a videotaping system; removing prisoners' socks; removing prisoners' clothing and providing them with paper suits; and installing wire mesh on the bars of cell doors. Based on these omissions, plaintiff claimed that defendants engaged in an unconstitutional custom, practice or policy.

The District Court granted summary judgment in favor of the municipal defendants. In doing so, the court thoroughly reviewed the development of the Third Circuit's legal standard for *Section 1983* liability in prisoner suicide cases, culminating with *Colburn I* and *Colburn II*. The District Court held that in order to state a cognizable claim under *Section 1983*, plaintiff had to show

the policymakers were aware of (1) the risk of suicides in city lockups, and (2) feasible alternatives for preventing them, and that they either (a) deliberately chose not to pursue those alternatives, or (b) acquiesced in a long-standing policy or custom of inaction.

Id. at 1412 (citing [*25] *Simmons v. City of Philadelphia, 947 F.2d 1042, 1067 (3d Cir. 1991)* (opinion announcing judgment of the court)). n12

n12 The District Court found deliberate indifference in *Simmons v. City of Philadelphia, 728 F.*

Supp. 352 (E.D. Pa. 1990), and its decision was affirmed by the Third Circuit in the above-cited judgment of the court. In *Simmons*, the City of Philadelphia lock-up officers admitted to having no training in suicide prevention, despite the fact that 20 people committed suicide in a five-year period in City lock-ups under circumstances similar to the decedent's. *Id. at 356.* The City failed to implement numerous preventative measures which could have saved the decedent; the officers took no preventative action despite knowing that the decedent was high-risk; and they made no effort to perform any type of resuscitation after he was found hanging in his cell. *Id. at 353-354.*

Applying the foregoing standard, the District Court noted **[*26]** that only three successful suicides and several attempted suicides had occurred in the six years preceding Chain's attempt to hang himself. During that time the municipality had adopted policies requiring the removal of excess clothing and observation of detainees to prevent such incidents. The municipality's actions, in the court's view, did not communicate a message of tacit approval of, or acquiescence in, prisoner suicides. Rather, the policy reflected a reasonable response to the risk of suicide, and went beyond the steps taken in other cases where a similar constitutional challenge to a suicide prevention policy was rejected. *See, e.g., Williams v. Borough of West Chester, 891 F.2d 458 (3d Cir. 1989)* (plaintiff claimed that municipality had violated decedent's rights by failing to require removal of detainees' belts, install visual surveillance equipment, allocate funds for mental health treatment, and train officers in handling at-risk detainees). Accordingly,

the *Litz* court held that the failure of the city to adopt the additional measures identified by plaintiff at most amounted to "mere negligence, which falls short of the threshold for stating a *Section* [*27] *1983* claim." *Litz, 896 F. Supp. at 1413.*

As in *Litz*, the Estate's challenge to the Policy is not based upon evidence tending to show "a level of culpability higher than a negligent failure to protect [Decedent] from self-inflicted harm." *Colburn II, 946 F.2d at 1024.* The Estate had to demonstrate that Meisel had subjective knowledge of a substantial risk of serious harm to suicidal inmates and consciously chose to disregard that risk. The Estate had to show what the Supreme Court has characterized as a "culpable state of mind" that is "more blameworthy than negligence." *Farmer, 511 U.S. at 834, 835.* The Third Circuit has characterized this state of mind as "scienter-like evidence of indifference on the part of a particular policymaker or policymakers." *Simmons, 947 F.2d at 1060-1061.* n13 The Estate simply failed to demonstrate this requisite culpable state of mind on the part of Meisel.

n13 Although *Simmons* was a plurality decision, the Third Circuit cited the "scienter-like evidence" language with approval in *Parkway Garage, Inc. v. City of Philadelphia, 5 F.3d 685, 692 (3d Cir. 1993), abrogated on other grounds, United Artists Theatre Circuit, Inc. v. Township of Warrington, 316 F.3d 392 (3d Cir. 2003).*

[*28]

Significant to the trial court's analysis, and our own, is the fact that there was only one inmate sui-

cide at the Prison before Decedent's, and that incident occurred in 1995, seven years before Decedent took his own life. Moreover, the Estate's own evidence showed that there were only five suicide attempts between 2000 and 2002, including Decedent's first attempt. There was certainly no pattern of such incidents that showed that there was an obvious risk which the Policy did not address. Stated otherwise, there was no circumstantial evidence presented by the Estate that would have allowed the trial court to find that there was a substantial risk of suicide created by the Policy that was known to Meisel. n14 *Farmer, 511 U.S. at 842, Beers-Capitol, 256 F.3d at 133.* To the contrary, given the large number of persons that passed through the Prison during Meisel's tenure, in excess of 50,000, and the infrequent suicides, three between 1989 and 2003, the Policy appeared to be effective in preventing suicides by inmates.

n14 Actual knowledge could be demonstrated by evidence showing that a substantial risk of inmate suicides was "longstanding, pervasive, well-documented, or expressly noted by prison officials in the past, and the circumstances suggest that the defendant-official being sued had been exposed to information concerning the risk...then such evidence could be sufficient to permit a trier of fact to find that the defendant-official had actual knowledge of the risk." *Farmer, 511 U.S. at 842-843.*

[*29]

The final piece of the Estate's claim against Meisel is the assertion that the Policy, ineffective as it was, was not properly implemented. The Estate

contends that the suicide precaution cell in which Decedent was last housed, Cell 3223, in addition to not being suicide-resistant, was not clearly observable from the guard control booth, as required by the Policy. The Estate asserts that the slighting between the control booth and Cell 3223 was partially obstructed by an open staircase. A completely unobstructed slighting between the booth and Cell 3223 would have allowed for better observation of Decedent and prevented him from hanging himself.

However, the Estate failed to produce any evidence that Meisel knew that Cell 3223 was unsafe and continued to use it as a suicide prevention cell. In the absence of this knowledge, Meisel cannot be found deliberately indifferent, even if we accept the Estate's premise that Cell 3223 was an inappropriate cell in which to place Decedent.

This is also the flaw in the Estate's claim that Decedent should have been placed under constant observation. The Estate presented no evidence that had the medical staff directed more observation of Decedent, [*30] it would not have been provided. As noted by the trial court, suicide is a mental health issue, and the custodial officers relied upon the advice of mental health professionals in dealing with Decedent. This is not deliberate indifference by anyone at the Prison, least of all by Meisel.

This is undeniably a tragic case. A single suicide in any correctional facility is one too many. Nevertheless, as the Third Circuit admonished, "we cannot place . . . custodial officers and employees 'in the position of guaranteeing that inmates will not commit suicide.'" *Colburn II, 946 F.2d at 1030-1031* (quoting *Colburn I, 838 F.2d at 669*). At every stage of Dece-

dent's incarceration, the officers supervised by Meisel made a concerted effort to keep Decedent safe and to prevent him from harming himself. Decedent was evaluated by medical staff and placed on increased levels of observation as warranted, including physical restraint. He was frequently observed by Prison officials in accordance with the Policy. n15 The Estate simply presented no evidence that Meisel consciously made decisions with respect to Decedent individually, or suicidal inmates generally, to place [*31] him and other suicidal inmates at risk.

n15 Based upon these uncontradicted facts, the trial court observed as follows:

[D]ecedent's placement on suicide watch by the medical staff and the [D]ecedent's ultimate placement in Cell 3223 were reasonable under the circumstances |. The record reflects that Defendant Dale Meisel, as a supervisor, acted reasonably with respect to the [D]ecedent and his risk of suicide, and [D]ecedent's injury does not bear a close causal relationship to Defendant Dale Meisel's alleged failure to respond adequately.

Trial Court Opinion at 15-16. The Estate contends that it was for the jury, not the trial court, to make these findings of reasonableness. The Estate's argument here is flawed.

—First, the holding of the trial court did not turn on the question of whether Meisel responded reasonably to Decedent's medical needs but whether Meisel had subjective knowledge of Decedent's particular situa-

tion. Because Meisel did not have actual knowledge about Decedent, the inquiry does not need to go to the next step directed by *Farmer, i.e.*, whether the prison official acted reasonably. *Farmer, 511 U.S. at 844.* Accordingly, the trial court's above-cited observations are not central to the holding and, thus, are *dicta*.

Second, we disagree that the conclusion of whether a prison official with actual knowledge acted reasonably, assuming it were dispositive in this case, is a factual question. It is for the courts to determine, under *Farmer*, whether particular conduct is so unreasonable as to constitute the infliction of cruel and unusual punishment.

We agree with Meisel and Lehigh County that the Estate's argument twists the deliberate indifference inquiry into a question of whether a prison policy or practice was reasonable. That is not what *Farmer* teaches.

[*32]

Lehigh County Liability

Section 1983 provides a vehicle by which a citizen may seek redress from a person who, acting under color of state law, deprives an individual of rights, privileges or immunities secured by the United States Constitution. *42 U.S.C. § 1983.* A municipality is a "person" that can be sued directly under *Section 1983* and held liable, in some circumstances. *Monell v. Dep't of Soc. Servs., 436 U.S. 658, 690, 98 S. Ct. 2018, 56 L. Ed. 2d 611 (1978).* Of course, municipal officials acting in their official capacity are also considered "persons" under *Section 1983. Id. at 690, n. 55.* A municipality cannot, however, be held liable

under *Section 1983* on a *respondeat superior* theory. *Id. at 691.* Rather, liability will be imposed when the municipality implements an official policy that is either unconstitutional on its face or is the "moving force" behind the constitutional tort of one of its employees. *Id. at 694; Polk County v. Dodson, 454 U.S. 312, 326, 102 S. Ct. 445, 70 L. Ed. 2d 509 (1981).* n16

n16 A concededly valid official policy may be deemed the "moving force" behind a constitutional tort when it is "unconstitutionally applied by a municipal employee." *City of Canton, Ohio v. Harris, 489 U.S. 378, 387, 109 S. Ct. 1197, 103 L. Ed. 2d 412 (1989)* (wherein police officers did not summon medical assistance for plaintiff, who fell down several times and became incoherent while being processed at the police station for a speeding violation). Municipal liability under *Section 1983* will lie if the municipality's failure to adequately train its employees results in the constitutional deprivation, *and* the "failure to train" reflects deliberate indifference to the constitutional rights of its inhabitants. *Id. at 392.* The Estate does not assert a "failure to train" theory of liability, opting instead to challenge the Policy itself as unconstitutional.

[*33]

The trial court held that because the Estate failed to show a constitutional violation by a municipal actor, Meisel, its claim against Lehigh County failed as a matter of law. We agree.

The United States Supreme Court has held that *Monell* does not authorize

the award of damages against a municipal corporation based on the actions of one of its officers when in fact the jury has concluded that the officer inflicted no constitutional harm. If a person has suffered no constitutional injury at the hands of the individual police officer, the fact that the departmental regulations might have *authorized* the use of constitutionally excessive force is quite beside the point.

City of Los Angeles v. Heller, 475 U.S. 796, 799, 106 S. Ct. 1571, 89 L. Ed. 2d 806 (1986) (emphasis original). In *Trigalet v. City of Tulsa, Oklahoma, 239 F.3d 1150 (10th Cir. 2001)*, the Court of Appeals held, consistent with nearly every other Court of Appeals, that a municipality cannot be held liable in a *Section 1983* action in the absence of a predicate unconstitutional act by the municipality's employee. Even if the municipality's actions are arbitrary or even "conscience **[*34]** shocking, in a constitutional sense" the municipality cannot be held liable under *Section 1983. Id. at 1151.* This is because a claim of "inadequate training [or] supervision . . . under *§ 1983* cannot be made out against a supervisory authority absent a finding of a constitutional violation by the person supervised." *Id. at 1154* (quoting *Webber v. Mefford, 43 F.3d 1340, 1344-45 (10th Cir. 1994)).*

This Court has expressly adopted the *Trigalet* analysis. *Thomas v. City of Philadelphia, 804 A.2d 97, 112 (Pa. Cmwlth. 2002)* ("We hold, therefore, that in the absence of an underlying unconstitutional action by employees of the City . . ., we will not consider the question of whether the City [has liability] . . ."); *Robbins v. Cumberland County Children and*

nounced by our Supreme Court in *Borough of Nanty-Glo v. American Surety Co. of New York, 309 Pa. 236, 163 A. 523 (1932).* The so-called *Nanty-Glo* rule provides that a court may not summarily enter a judgment based upon oral testimony since the credibility of such testimony is within the province of the jury. The Estate argues that the trial court erred by relying upon Meisel's deposition testimony that Prison officials will provide for constant observation of a suicidal inmate when directed to do so by medical staff. The Estate also makes a vague assertion that the trial court erroneously considered Meisel's and Sweeney's testimony that "various alternatives were or were not reasonable or feasible to support Summary Judgment." Appellants' Brief at 24.

The *Nanty-Glo* rule is not applicable to every summary judgment proceeding. *Kirby v. Kirby, 455 Pa. Super. 96, 687 A.2d 385, 388 (Pa. Super. 1997).* Rather, our appellate courts follow a three-step analysis to determine whether the *Nanty-Glo* [*37] rule will preclude a grant of summary judgment:

Initially, it must be determined whether the plaintiff has alleged facts sufficient to establish a prima facie case. If so, the second step is to determine whether there is any discrepancy as to any facts material to the case. Finally, it must be determined whether, in granting summary judgment, the trial court has usurped improperly the role of the jury by resolving any material issues of fact.

Id. at 388, cited with approval in Azar v. Ferrari, 898 A.2d 55, 61 n.9 (Pa. Cmwlth. 2006).

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Id. at 388, cited with approval in Azar v. Ferrari, 898 A.2d 55, 61 n.9 (Pa. Cmwlth. 2006).

Applying the foregoing test, we find that the *Nanty-Glo* rule is not applicable in this case. While it may be true that the trial court referred to deposition testimony from Meisel, Sweeney and other Prison officials regarding the Prison's policies and practices, that testimony was not dispositive or, in the end, even material to the judgment. As explained at length above, the Estate failed to adduce facts sufficient to establish that Meisel and Lehigh County acted with *deliberate indifference* toward Decedent's known vulnerability to suicide. Therefore, under the first prong of *Kirby*, the Estate failed **[*38]** to establish a *prima facie* case under *42 U.S.C. § 1983*.

Conclusion

For the foregoing reasons, we affirm the order of the trial court granting summary judgment in favor of the County of Lehigh and Dale Meisel. n18

n18 In its brief and reply brief to this Court, the Estate argues that the trial court erred by failing to consider whether Meisel and Lehigh County could be held liable under a "state-created danger" theory. We note that this theory of liability is not set forth in the complaint. Assuming, *arguendo*, that the Estate raised and preserved a state-created danger claim, it would not be entitled to relief under that doctrine. In *Robbins v. Cumberland County Children and Youth Services, 802 A.2d 1239 (Pa. Cmwlth. 2002)*, this Court adopted the standard followed by the Third Circuit for liability under the state-created danger theory in *Section 1983* actions. That standard requires that:

(1) the harm ultimately caused was foreseeable and fairly direct; (2) *the State actor acted in willful disregard for the safety of the plaintiff;* (3) there existed some relationship between the State and the plaintiff; [and] (4) the State actors used their authority to create an opportunity that otherwise would not have existed for the third party's crime to occur.

Id. at 1247 n.8 (citing *Kneipp v. Tedder, 95 F.3d 1199, 1208 (3d Cir. 1996))* (emphasis added). In *Kneipp* the Third Circuit equated "willful disregard" with "deliberate indifference." *Id. at 1208 n. 21.* In the present case, regardless of the theory advanced, the Estate failed to adduce evidence sufficient to demonstrate that the Policy or the actions of Meisel and Lehigh County were deliberately indifferent to Decedent's vulnerability to suicide. Therefore, the Estate's state-created danger theory of liability would have failed as a matter of law.

[*39]

MARY HANNAH LEAVITT, Judge

ORDER

AND NOW, this 3rd day of May, 2007, the order of the Court of Common Pleas of Lehigh County in the above-captioned matter, entered April 26, 2006, is hereby AFFIRMED.

MARY HANNAH LEAVITT, Judge

IN THE COURT OF COMMON PLEAS OF LEHIGH COUNTY, PENNSYLVANIA CIVIL DIVISION

RUTH AROCHO, AS ADMINISTRATRIX OF THE ESTATE OF ENRIQUE RENE VERAS AND WADAYS VERAS AND RUTH AROCHO AS PARENT AND GUARDIAN OF CRYSTAL VERAS AND YASHERA VERAS,
Plaintiffs

vs.

COUNTY OF LEHIGH AND DALE MEISEL,
Defendants

No. 2003-C-3235

* * * * * * * *

APPEARANCES:
DAVID L. DERATZIAN, ESQUIRE,
On behalf of the Plaintiffs
RUDOLPH ZIEGER, ESQUIRE,
THOMAS M. CAFFREY, ESQUIRE,
On behalf of the Defendants

* * * * * * * *

OPINION
LAWRENCE J. BRENNER, J.

On or about December 8, 2003, the Plaintiffs, Ruth Arocho, as the Administratrix of the decedent's estate and as the mother of the decedent's minor children, Crystal Veras and Yashera Veras, and Wadays Veras, an adult child of the decedent,

instituted the within action by filing a Summons. Thereafter, on or about December 10, 2004, the Plaintiffs filed a Complaint. In the Complaint, as amended, the Plaintiffs allege that on or about December 5, 2002, due to a significant history of mental illness, the decedent, Enrique Rene Veras, was placed on suicide watch in Lehigh County Prison. While on constant video surveillance, the decedent fashioned a noose from his bedding and hanged himself in his cell. The Plaintiffs seek redress against the Defendants under 42 U.S.C.A. § 1983, alleging that the Defendants violated the decedent's rights under the United States Constitution when the decedent committed suicide in Lehigh County Prison. Specifically, in the Complaint, the Plaintiffs seek to impose liability upon Defendant Dale Meisel, in his supervisory capacity as the Warden of Lehigh County Prison, under 42 U.S.C.A. § 1983. Further, the Plaintiffs seek to impose municipal liability upon Defendant County of Lehigh under 42 U.S.C.A. § 1983 as a result of Lehigh County Prison's Suicide Prevention Policy, which, according to the Plaintiffs, is an unconstitutional policy that caused the decedent's death.

Presently before this Court is the Motion for Summary Judgment of the Defendants. In the Motion for Summary Judgment, the Defendants argue that they were not "deliberately indifferent" to the decedent's risk of suicide. Consequently, the Defendants believe that they are entitled to Summary Judgment. Plaintiffs responded to this Motion for Summary Judgment on December 14, 2005. Oral argument was conducted on the within matter on January 3, 2006. On the same date, this

Court entered an Order denying the Motion for Summary Judgment. On March 3, 2006, the Defendants filed a Motion to Reconsider this interlocutory Order. *Buehl v. Horn*, 728 A.2d 973 (Pa. Cmwlth. 1999); *Key Automotive Equipment Specialists, Inc. v. Abernethy*, 431 Pa. Super. 358, 362, 636 A.2d 1126, 1128 (1994); *Hutchinson v. Luddy*, 417 Pa. Super. 93, 108, 611 A.2d 1280, 1288 (1992); *Cf.* 42 Pa. C.S.A. § 5505. Said Motion to Reconsider was granted by this Court. Then, oral re-argument was conducted on April 17, 2006. Initially we note that summary judgment is properly granted where pleadings, depositions, answers to interrogatories and admissions on file, together with affidavits, if any, show that there is no genuine issue of material fact and that the moving party is entitled to judgment as a matter of law. *Merriweather v. Philadelphia Newspapers, Inc.*, 453 Pa. Super. 464, 471, 684 A.2d 137, 140 (1996), *allocatur denied*, 548 Pa. 628, 693 A.2d 967 (1997); *Coleman v. Coleman*, 444 Pa. Super. 196, 199, 663 A.2d 741, 742-743, *appeal denied*, 543 Pa. 722, 673 A.2d 330 (1995). Moreover, when considering a motion for summary judgment, the Court must examine the record in the light most favorable to the nonmoving party, accepting as true all well pleaded facts and all inferences to be drawn therefrom. *Electronic Lab. Supply Co. v. Cullen*, 712 A.2d 304 (Pa. Super. 1998); *Coleman*, 444 Pa. Super. at 199, 663 A.2d at 742-743.

Furthermore, 42 U.S.C.A. § 1983 provides a remedy against any person who, acting under color of state law, deprives another of rights, privileges, or immunities secured by the Constitution or the law of the United States. 42 U.S.C.A. §1983. This

statute is not, however, a source of substantive rights, but instead, merely provides "a method for vindicating federal rights elsewhere conferred." *Graham v. Connor*, 490 U.S. 386 (1989). The Eighth Amendment applicable to the states under the Fourteenth Amendment, prohibits the cruel and unusual punishment of prisoners, thereby entitling them to medical attention for serious health needs. *Dimitris v. Lancaster County Prison Bd*, 2002 WL 32348283 (E.D. Pa. 2002). 42 U.S.C.A. § 1983 allows recovery for constitutional violations when a prisoner commits suicide after receiving inadequate attention based on his mental health condition. Id. at 5.

DEFENDANT DALE MEISEL:

This Court recognizes that in *Colburn v. Upper Darby Township*, 946 F.2d 1017, 1023-1024 (3rd Cir. 1991), the Third Circuit stated that:

> [A] plaintiff in a prison suicide case has the burden of establishing . . . (1) the detainee had a "particular vulnerability to suicide,"[1] (2) the custodial officer or officers knew or should have known of that vulnerability,[2] and (3) those officers "acted with reckless indifference" to

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[1] In *Colburn v. Upper Darby Township*, 838 F.2d 663 (3rd Cir. 1988), the Third Circuit "established the standard for liability to be applied in this circuit in prison suicide cases." *Colburn*, 946 F.2d at 1023.

[2] *Farmer v. Brennan*, 511 U.S. 825, 836, 114 S.Ct. 1970, 1978 (1994) dispensed with the "should have known" in the second prong.

> the detainee's particular vulnerability.[3]

Colburn, 946 F.2d at 1023-1024. Of note, the Third Circuit has used the concept of "reckless indifference" and the concept of "deliberate indifference" interchangeably. *See Colburn*, 946 F.2d at 1024. The United States Supreme Court added that "[w]ith deliberate indifference lying . . . between . . . negligence . . . and purpose or knowledge . . . [i]t is fair to say that acting or failing to act with deliberate indifference to a substantial risk of serious harm to a prisoner is the equivalent of recklessly disregarding that risk." *Farmer v. Brennan*, 511 U.S. 825, 836, 114 S.Ct. 1970, 1978 (1994). Noting that "recklessly" is not self-defining, the United States Supreme Court defined "deliberate indifference":

> We reject . . . an objective test. . . . We hold instead that a prison official cannot be found liable under the Eighth Amendment for denying an inmate humane conditions of confinement unless the *official knows of and disregards an excessive risk to inmate health or safety; the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the*

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[3] At the time of oral argument, the Defendants conceded that prongs (1) and (2) have been satisfied. The conflict revolves around prong number (3).

> *inference*. . . an official's failure to alleviate a significant risk that he should have perceived but did not, while no cause for commendation, cannot under our cases be condemned as the infliction of punishment.

Farmer, 511 U.S. at 838-839, 114 S.Ct. at 1979 (emphasis supplied). The *Farmer* case applies to inmate suicide cases.

In the instant case, the record plainly reveals that in February of 2002 the decedent was incarcerated and immediately placed on "suicide precaution" status. On February 11, 2002, the decedent tied a makeshift rope around his neck and tied it to the bars in a suicide attempt. The correctional officers cut the noose and thwarted the suicide attempt. The decedent remained on suicide precaution status until February 21, 2002, when he was downgraded to "close observation" status. The decedent was removed from "close observation" status on February 25, 2002. The decedent was returned to "suicide precaution" status on March 30, 2002 and remained on this status until he was released from Lehigh County Prison on April 2, 2002.

The decedent returned to Lehigh County Prison on October 27, 2002, at which time he was placed on "suicide precaution" status. After he engaged in selfinjurious behavior, he was placed in a restraint chair with the authorization of the medical department and remained on "suicide precaution" status. Then, on October 28, 2002, the decedent again attempted suicide by tying a strip of blanket around his neck and attaching it to the cell bars.

Correctional officers again thwarted the suicide attempt by the decedent and the decedent was placed in a restraint chair. On November 4, 2002, the decedent was transferred to the Mental Health Unit and remained on "suicide precaution" status. The decedent was removed from "suicide precaution" status on November 14, 2002.

Subsequently, on December 4, 2002, the decedent became enraged upon being informed that he was being switched to a different cell in the Mental Health Unit and the decedent began to engage in self-injurious behavior. Consequently, the decedent was placed in a "suicide precaution cell", specifically Cell 3223 that is located in the Administrative Segregation/Disciplinary Segregation Unit.[4] It should be noted that in order for a cell to be used as a "suicide precaution cell," it must be subject to the best sight line available from the control booth. Furthermore, a "suicide precaution cell" must also be an open bar cell. A cell is designated a "suicide

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[4] In the Administrative Segregation/Disciplinary Segregation Unit, there are three (3) correctional officers assigned (except in the evening), in contrast to other units of Lehigh County Prison where only one (1) correctional officer is assigned. Of the three (3) correctional officers assigned to this Unit, one (1) of the correctional officers is assigned to the booth and the other two (2) correctional officers are assigned to walk the pod. The correctional officer in the booth is responsible for monitoring an inmate who, pursuant to the Suicide Prevention Policy, requires observation. However, all of the correctional officers in the Administrative Segregation/Disciplinary Segregation Unit are responsible for observing a potentially suicidal inmate, and if the correctional officer in the booth cannot observe the inmate from the control booth, one (1) of the other correctional officers on the pod is required to go to the cell in order to check on the inmate.

precaution cell" based upon the recommendations of both the custody staff and the treatment staff. Indeed, one of Lehigh County Prison's psychiatrists conducts an ongoing evaluation of the cells used by Lehigh County Prison as "suicide precaution cells" and reviews whether the cells have direct access to the officers and are in the visual field of the officers most of the time to make sure that there is nothing that the prisoners can hang themselves with or hang onto. The "suicide precaution cell," Cell 3223, was thoroughly searched by four (4) different correctional officers for any objects that would allow the decedent to harm himself prior to the decedent's placement.[5]

Immediately after being placed in Cell 3223, the decedent again acted out, including an attempt to hang himself by tying his underwear around his neck and to the towel bar in the cell. As a result, the decedent, upon authorization from the medical department, was placed in a restraint chair between 8:45 P.M. and 9:00 P.M. The decedent was given a blanket and was stripped naked. Between 10:30 P.M. and 10:45 P.M., correctional officers attempted to remove the decedent from the restraint chair, but the decedent refused to leave the restraint chair, stating that he would harm himself if he were removed. The medical

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[5] Although Defendant Dale Meisel acknowledges that Cell 3223 does not comply with National Commission on Correctional Health Care Standards because it has fold down hooks, Cell 3223 is an open barred grill and is subject to a good sight line from the control booth. Therefore, Defendant Dale Meisel testified that he believes that Cell 3223 was and continues to be an appropriate suicide precaution cell.

department placed the decedent on "suicide precaution" status at 11:18 P.M. The decedent was removed from the restraint chair at 12:30 A.M. on December 5, 2002. On the morning of December 5, 2002, the decedent was given a mattress in his cell. The mattress was checked by the correction officer. Moreover, the decedent was checked every thirty (30) minutes from midnight through 7:30 A.M. on December 5, 2002, and thereafter every fifteen (15) minutes through 4:00 P.M. On December 5, 2002 at approximately 4:10 P.M. the decedent was found in Cell 3223 standing with his back to the cell door with a ligature around his neck and tied to the cell door. The ligature was characterized as bed linen or a sheet. The correctional officers immediately cut the ligature and summoned medical attention. The decedent was transferred to the hospital where he was pronounced dead at 4:54 P.M.

Based on the record in this case, Defendant Dale Meisel, the Warden of Lehigh County Prison, did not have any direct involvement with respect to the decedent's suicide. Consequently, the Plaintiffs have failed to sustain their burden of establishing the aforementioned three (3) elements as outlined in the *Colburn* case to demonstrate that Defendant Dale Meisel would bear liability for any direct action. In particular, Defendant Dale Meisel did not act with reckless indifference with respect to the decedent's suicidal ideations and attempts to kill himself.

Furthermore, Defendant Dale Meisel bears no liability for his actions as a supervisor.[6] The Third Circuit has applied the deliberate indifference standard to supervisors:

> [B]ased on . . . *City of Canton v. Harris*, 489 U.S. 378, 109 S.Ct. 1197 . . . (1989) . . . to hold a supervisor liable because his policies or practices led to an Eighth Amendment violation, the plaintiff must identify a specific policy or practice that the supervisor failed to employ and show that: (1) the existing policy or practice created an unreasonable risk of the Eighth Amendment injury; (2) the supervisor was aware that the unreasonable risk was created; (3) the supervisor was indifferent to that risk; and (4) the injury resulted from the policy or practice. *See Sample* [*v. Diecks*], 885 F.2d [1099] at 1118 [(3d Cir. 1989)].
>
> . . . one way . . . a plaintiff can make out a supervisor liability claim is by showing that "*the supervisory official failed to respond appropriately in the face of an awareness of a pattern of such injuries.*" *Id.* But that is not the

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[6] As the Warden, Defendant Dale Meisel is responsible for making formal Lehigh County Prison policy which must be co-signed by Edward Sweeney, the Director of Corrections. Defendant Dale Meisel is responsible for the training of the correctional officers and enforcing Lehigh County Prison policies through the chain of command.

> only way to make out such a claim, as "*there are situations in which the risk of constitutionally cognizable harm is so great and so obvious that the risk and the failure of supervisory officials to respond will alone support findings of the existence of an unreasonable risk, of knowledge of that unreasonable risk, and of indifference to it.*" *Id.*
>
> . . . seeking to hold supervisors liable for their deficient policies, *Sample*'s four-part test provides the analytical structure for determining whether the policymakers exhibited deliberate indifference to the plaintiffs' risk of injury, it being simply the deliberate indifference test applied to the specific situation of a policymaker.

Beers-Capitol v. Whetzel, 256 F.3d 120, 134-135 (3d Cir. 2001) (emphasis supplied). The *Beers-Capitol* decision noted that "nothing in the *Sample* opinion that we rely on here conflicts with *Farmer*. Id. at 134 n. 7. Further, *Sample* stated:

> The [*Canton*] Court went on to caution . . . that "for liability to attach . . . the identified deficiency in a city's training program must be closely related to the ultimate injury."
>
> * * *
>
> Although the issue here is one of individual liability rather than of the liability of a political subdivision, we

> are confident that . . . the standard of individual liability for supervisory public officials will be found to be no less stringent than the standard of liability for the public entities they serve.
>
> * * *
>
> Under . . . *Canton* it is not enough . . . to argue that the constitutionally cognizable injury would have occurred if the superior had done more than he or she did. The district court must insist that *Sample* identify specifically what it is that Robinson failed to do that evidences his deliberate indifference. Only in the context of a specific defalcation on the part of the supervisory official can the court assess whether the official's conduct evidences deliberate indifference and whether there is a close causal relationship between the "identified deficiency" and the "ultimate injury." Normally, an unreasonable risk in a supervisor liability case will be shown by evidence that such harm has in fact occurred on numerous occasions.

Sample, 885 F.2d at 1117-1118. Additionally, *Farmer* rejected *Canton*'s definition of "obvious" in prison settings:

> *Canton*'s objective standard, however, is not an appropriate test for determining the liability of prison officials under the Eighth Amendment

> as interpreted in our cases. . . . [w]e cannot accept petitioner's argument that *Canton* compels the conclusion here that a prison official who was unaware of a substantial risk of harm to an inmate may nevertheless be held liable under the Eighth Amendment if the risk was obvious and a reasonable prison official would have noticed it.

Farmer, 511 U.S. at 841-842, 114 S.Ct. at 1981. However, the Court added the following:

> [A]n Eighth Amendment claimant need not show that a prison official acted or failed to act believing that harm actually would befall an inmate; it is enough that the official acted or failed to act despite his knowledge of a substantial risk of serious harm. . . . Whether a prison official had the requisite knowledge of a substantial risk is a question of fact subject to demonstration in the usual ways . . . , and a fact finder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious.

Id. at 842-843, 114 S.Ct. at 1981-1982. *Beers-Capitol*, an Eighth Amendment case where Liggett was sued as a supervisor, recognized Farmer's definition of "obvious":

> The deliberate indifference standard as set out in *Farmer* is a high one,

> however – requiring actual knowledge or awareness on the part of the defendant . . . whether the above policies and practices created a risk of harm . . . that was 'so great and so obvious' that [supervisor] Liggett must have known of the excessive risk but was indifferent to it.

Beers-Capitol, 256 F.3d at 125, 135-137. Further, prison officials who actually know of a substantial risk to inmate health or safety may be found free from liability if they respond reasonably to the risk, even if the harm ultimately was not averted. *Farmer*, 511 U.S. at 844, 114 S.Ct. at 1982-1983.

Moreover, the existence of an obvious risk can sometimes be inferred from a long-standing pattern or practice that would have alerted a defendant to a risk of maintaining a course of action. In the within matter, there is no pattern of relevant injury. Indeed, the record reflects that approximately 6,500 inmates pass through Lehigh County Prison each year and from 1993 until December of 2002, Lehigh County Prison housed approximately 50,000 inmates. Also, Lehigh County Prison records indicate that from February of 1989, when Defendant Dale Meisel's tenure in the department of correction started, until December 4, 2002, there was only one (1) inmate suicide which occurred in 1995. In fact, Defendant Dale Meisel was only aware of three (3) inmates suicides: one (1) in 1995, the decedent's suicide and one (1) after the decedent's suicide. Thus, Defendant Dale Meisel

could not be aware of any pattern of suicides, as none existed.[7]

Furthermore, Defendant Dale Meisel, as a supervisor, acted reasonably with respect to the decedent and his risk of suicide, and decedent's injury does not bear a close causal relationship to Defendant Dale Meisel's alleged failure to respond adequately. The National Commission on Correctional Heath Care's Suicide Prevention Standard J-51 stated, in relevant part to decedent's suicide:

Key components of a suicide prevention program include the following:

> 3. Assessment. This should be conducted by a qualified mental health professional, who designates the inmate's level of suicide risk.
>
> 4. Monitoring. The plan should specify the facility's procedures for monitoring an inmate who has been identified as potentially suicidal. Regular documented supervision should be maintained. . . .
>
> 5. Housing. A suicidal inmate should not be housed or left alone.

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[7] Further, it should be noted that there were only five (5) suicide attempts, including the decedent's suicide attempt that resulted in hospitalization, from 2000 through 2002 in the Lehigh County Prison.

> An appropriate level of observation must be maintained. If a sufficiently large staff is not available that constant supervision can be provided when needed, the inmate should not be isolated. Rather, s/he should be housed with another resident or in a dormitory and checked every 10-15 minutes. An inmate assessed as being a high suicide risk always should be observed on a continuing, uninterrupted basis or transferred to an appropriate health care facility. The room should be as nearly suicide-proof as possible (i.e., without protrusions of any kind that would enable the inmate to hang him/herself).
>
> 6. Referral. The plan should specify the procedures for referring potential suicidal inmates and attempted suicides to mental health care providers or facilities.

See The National Commission on Correctional Heath Care's Suicide Prevention Standard J-51.

At issue in this case is Lehigh County Prison's Suicide Prevention Policy which is the Lehigh County Prison Policy 5.5, Suicide Prevention, effective April 20, 2001.[8] The stated purpose of the

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[8] This Suicide Prevention Policy is supplemented by Lehigh County Prison's practices, policies and procedures. Also, at the time of the decedent's death the Suicide Prevention Policy was

Suicide Prevention Policy is "[t]o provide written procedures regarding Lehigh County Prison's Suicide Prevention Program in order to protect inmates from self-harm or death." The Suicide Prevention Policy further provides that "[i]t is the policy of Lehigh County Prison to provide special housing, increased levels of observations, and medical restraint to those inmates who display self-destructive behavior."

The Suicide Prevention Policy initially provides for the identification and referral of potentially suicidal inmates. All inmates are initially evaluated by a registered or licensed practical nurse for suicide risk. Inmates who express suicidal ideation or behaviors to a staff member are immediately referred to the medical staff for evaluation. Specifically, inmates identified as potentially suicidal are evaluated by a nurse or psychiatrist. If the evaluator determines that the inmate requires an increased level of attention, he or she may order close observations, suicide precautions or medical restraint.[9] The evaluator's determination is communicated to Lehigh County Prison staff both verbally and in writing. Under "close observations," there is a specified time interval for checking on an inmate's behavior. Lehigh County Prison staff is required to document what is observed and this

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supplemented by the policy and procedures adopted by Wexford Health Sources, the independent medical provider at Lehigh County Prison. Wexford Health Sources' policies provide for medical autonomy by its medical staff.

[9] The Suicide Prevention Policy provides for incremental levels of observation and care.

information is submitted to the medical department for further evaluation.

The next level of observation and care under the Suicide Prevention Policy is "suicide precaution," which involves placing the inmate in an open barred cell for direct observation, removing the inmate's clothing and all other cell contents. This level of observation and care requires the following:

> 1. The housing unit officer shall issue a heavy blanket in good structural condition to the inmate.
>
> 2. The nurse shall place the inmate on finger foods/no utensil status.
>
> 3. The housing unit officer shall offer a daily shower to the inmate and directly supervise the inmate showering.
>
> 4. The housing unit officer shall monitor the inmate at irregular fifteen-minute intervals (no more than fifteen minutes between checks). The checks are staggered so that there is no predictable pattern for the inmate to use in planning suicide.[10]

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[10] More frequent monitoring of the inmate is permitted and the Lehigh County Prison psychiatrist can issue a medical order requiring the staff to observe a potentially suicidal inmate more frequently than fifteen minute intervals. In fact, the Lehigh County Prison psychiatrist can order constant observation of a potentially suicidal inmate if he believes that

> 5. The housing unit officer shall document suicide checks on a psychiatric check form and submit it to the medical department at the end of each shift.
>
> 6. Medical staff shall review the check report each shift for significant changes in behavior.
>
> 7. Medical staff will have daily contact with the inmate.
>
> 8. In the event of an official visitor (i.e. attorney, parole officer) the inmate will be dressed and escorted to the appropriate visit area and remain under direct visual observation by the escorting officer.

See The Lehigh County Prison Policy 5.5, Suicide Prevention, effective April 20, 2001.

The next level of observation and care under the Suicide Prevention Policy is "medical restraints," which permits, pursuant to a physician's orders, the placement of an inmate in a restraint chair if the inmate exhibits extreme behavior that is or may be harmful to the inmate or others, and a no less restrictive treatment is appropriate. The use of

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this level of observation is required. In addition, the Lehigh County Prison psychiatrist can authorize the commitment of a potentially suicidal inmate under the Pennsylvania Mental Health Procedures Act.

medical restraints is subject to the following conditions:

1. The restraint chair is the only approved form of medical restraint.

2. Staff supervising the placing of an inmate into the restraint chair must be trained in its use.

3. Medical personnel must check the initial application of restraints to ensure circulation is not impaired.

4. The inmate will be dressed in clothing appropriate to temperature unless otherwise specified by the mental health order.

5. Medical staff shall make an assessment every two hours of the inmate's behavior, position, restraints, and health care needs (food, water, elimination, cleanliness) and ensure the needs are met.

6. The housing unit officer shall monitor the inmate at irregular fifteen minute intervals (no more than fifteen minutes between checks).

7. The housing unit officer shall document medical restraint checks on a psychiatric check report form and submit them to the medical department at the end of each shift.

8. Medical staff will review the check report each shift for any significant change in behavior.

9. The housing unit officer shall document each time the inmate is released from medical restraints, or the reason for not releasing the restraints.

10. Medical restraint orders shall not exceed twenty-four hours.

11. Medical restraints shall not be removed without a physician's order with the following exception. The housing unit officer shall remove the restraints every two hours for ten minutes unless the inmate is extremely agitated.

12. The inmate must be monitored continuously when out of medical restraints.

See The Lehigh County Prison Policy 5.5, Suicide Prevention, effective April 20, 2001.

The Suicide Prevention Policy also provides for the use of inmate monitors, which are used in the discretion of the medical staff to assist prison staff in directly observing inmates who are on close observations, suicide precautions, and medical

restraints.[11] *See* The Lehigh County Prison Policy 4.5, Inmate Monitors, effective November 26, 2002.

Based upon the record in the within matter, the Lehigh County Prison officials did not ignore or act recklessly with respect to the decedent's suicidal ideations and attempts to kill himself. On the contrary, Lehigh County Prison officials at every stage of the decedent's incarceration made a concerted effort to keep the decedent safe and to stop the decedent from committing suicide. Indeed, the decedent was examined by mental health professionals, including a psychiatrist. Lehigh County Prison officials responded to the decedent's conduct in accordance with the advice and recommendations made by these mental health professionals. The decedent was placed on "suicide precaution" status when warranted and the requirements of the Suicide Prevention Policy, including frequent observation of the decedent and the removal of the decedent's clothing, were followed by the Lehigh County Prison officials. Additionally, the decedent was placed in a restraint when authorized by the mental health professionals and the decedent was placed in a "suicide precaution" cell for appropriate observation.

Overall, the record reflects that the decedent's placement on suicide watch by the medical staff and the decedent's ultimate placement in Cell 3223 were reasonable under the circumstances. Indeed,

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[11]The use of inmate monitors does not, however, relieve prison staff from their responsibility to personally check on the condition of the inmate.

absent a reason to believe, or actual knowledge, that prison doctors or their assistants are mistreating or not treating a prisoner appropriately, a non-medical prison official will not be charged with the Eighth Amendment scienter requirement of deliberate indifference. *Spruill v. Gillis*, 372 F.3d 218, 236 (3d Cir. 2004).[12] The record is void of any evidence to establish that Lehigh County Prison officials knew that Cell 3223 was unsafe and nonetheless chose to utilize it as a suicide precaution cell.[13] In light of Lehigh County

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[12] The record evidence indicates that Defendant Dale Meisel relied on the independent contractor health care provider, Wexford Health Sources, and its physicians, nurses and other health care personnel.

[13] Specifically, the Plaintiffs assert that Cell 3223 was unsafe because it had open bars rather than a clear solid door and because it did not have an adequate sight line. Plaintiffs also complain about the decision of the Lehigh County Prison officials to house potentially suicidal inmates in the Administrative Segregation/Disciplinary Segregation Unit, as well as the decision of the Lehigh County Prison officials not to use constant observation of the decedent. However, the Plaintiffs' claims must fail because they are unable to present evidence to establish that the Lehigh County Prison officials knew that Cell 3223 was unsafe and used it nonetheless. Also, the Plaintiffs have failed to adduce any evidence to establish or raise an inference that the housing of suicidal inmates in the Administrative Segregation/Disciplinary Segregation Unit and/or the use of fifteen (15) minute observation intervals as opposed to constant observation rises to the level of deliberate indifference. Indeed, the decedent was placed on fifteen (15) minute observation intervals based on the decision of medical professionals. The medical professionals could have decided to place the decedent on more frequent observation intervals and the Lehigh County Prison officials would have complied with any directive from the medical professionals. Suicide is a mental health issue and the Lehigh County Prison officials acted appropriately by relying on the advice of mental health

Prison's lack of inmate suicide history, Defendant Dale Meisel had no reason to believe that the medical staff was mistreating suicidal-risk inmates such as the decedent. The record reflects that Defendant Dale Meisel, as a supervisor, acted reasonably with respect to the decedent and his risk of suicide, and decedent's injury does not bear a close causal relationship to Defendant Dale Meisel's alleged failure to respond adequately. Because the record evidence does not directly establish or raise an inference that Defendant Dale Meisel knew that Cell 3223 was unsafe and nevertheless chose to continue to use it as a suicide precaution cell, and examining the record in a light most favorable to the Plaintiffs, Defendant Dale Meisel was not deliberately indifferent to the decedent's risk of suicide. *Cf. Dimitris v. Lancaster County Prison Bd.*, 2002 WL 32348283 (E.D. Pa. 2002) (finding that the Eighth Amendment, applicable to the states under the 14th Amendment, prohibits cruel and unusual punishment of prisoners, thereby entitling them to medical attention for serious health needs and that Section 1983 allows recovery for constitutional violations when a prisoner commits suicide after receiving inadequate attention based on his mental health condition). Accordingly, summary judgment is appropriate as to Defendant Dale Meisel as a matter of law.

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professionals in dealing with the decedent. "Written policy and defined procedures require, and actual practice evidences, that decisions and actions regarding the health care services to inmates are the sole responsibility of qualified health care personnel and are not compromised for security reasons." NCCHC Standards, J-02 Medical Autonomy.

COUNTY OF LEHIGH:

This Court notes that a municipality cannot be held liable unless there is a constitutional violation by the municipal actor causing the plaintiff's harm. *Robbins v. Cumberland County Children & Youth Services*, 802 A.2d 1239, 1250-1251 (Pa. Cmwlth. 2002). *See also Mark v. Borough of Hatboro*, 51 F.3d 1137, 1149-1150 (3rd Cir. 1995) (noting that *Collins v. City of Harker Heights*, 503 U.S. 115 (1992) made clear that in the *Monell* case, the proper analysis requires the court to separate two different issues when a 42 U.S.C.A. § 1983 claim is asserted against a municipality: (1) whether the plaintiff's harm was caused by a constitutional violation, and if so, (2) whether the city is responsible for that violation). Thus, the Plaintiffs must establish a breach of a constitutional duty by a state actor before a cognizable claim may be asserted against the County of Lehigh. The Plaintiffs have failed to meet this burden.

As articulated above, the Plaintiffs cannot present evidence at trial that would enable a fact finder to conclude that a state actor violated the decedent's constitutional rights. Because the Plaintiffs cannot establish an underlying constitutional violation, their claim against the County of Lehigh must fail as a matter of law. *See Robbins*, 802 A.2d at 1250-1251.[14] Additionally, this Court recognizes that in *Monell v. Department of Social Services of the City*

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[14] While this Court believes that the analysis should end here and no further discussion is necessary, this Court, nonetheless, will proceed to address Plaintiffs' other claims.

of New York, 436 U.S. 658, 694, 98 S.Ct. 2018, 2037-2038 (1978), the Supreme Court held that local government may not be sued under 42 U.S.C.A. §1983 for an injury inflicted solely by its employees or agents. Instead, it is when execution of a government's policy or custom inflicts the injury that the government as an entity is responsible under 42 U.S.C.A. § 1983. *Id.* The Supreme Court has noted the need for a direct causal link between a municipal policy and the alleged constitutional deprivation. *Canton*, 489 U.S. at 385, 109 S.Ct. at 1203. Furthermore, a municipality may only be liable where its policies and/or customs, including training, are deliberately indifferent to others' rights. Canton, 489 U.S. at 388-390, 109 S.Ct. at 1204-1205. Specifically:

> [T]he inadequacy of police training may serve as the basis for § 1983 liability only where the failure to train amounts to deliberate indifference to the rights of persons with whom the police come into contact. . . . [A] municipality can be liable under § 1983 only where its policies are the moving force [behind] the constitutional violation. Only where a municipality's failure to train its employees in a relevant respect evidences a 'deliberate indifference' to the rights of its inhabitants can such a shortcoming be properly thought of as a 'city policy or custom' that is actionable under § 1983. . . . The issue . . . is whether the training program is adequate; and if it is not, the question

> becomes whether such inadequate training can justifiably be said to represent 'city policy.' . . . But it may happen that in light of the duties assigned to specific officers or employees the need for more or different training is so obvious, and the inadequacy so likely to result in the violation of constitutional rights, that the policymakers of the city can reasonably be said to have been deliberately indifferent to the need. In that event, the failure to provide proper training may fairly be said to represent a policy for which the city is responsible, and . . . held liable if it actually causes injury.

Id. If the policy or custom does not facially violate federal law, causation can be established only by demonstrating that the municipal action was taken with deliberate indifference as to its known or obvious consequences. *Berg v. County of Allegheny*, 219 F.3d 261, 276, (3d Cir. 2000), *cert. denied*, 531 U.S. 1072, 121 S.Ct. 762 (2001). In the instant case, Plaintiffs' entire municipal liability claim is based upon the County of Lehigh's alleged failure to have in place or adhere to the suggested standards of private organizations in the corrections field. Plaintiffs refer to the American Correctional Association and the National Commission on Correctional Health Care. Specifically, the Plaintiffs essentially seek to hold the County of Lehigh liable on two (2) different theories of relief. First, the Plaintiffs contend that the Lehigh County Prison's Suicide Prevention Policy is deficient

because it does not comply with the standard for prevention of custodial suicide established by the American Correctional Association and the National Commission on Correctional Health Care. In particular, the Plaintiffs allege that the Lehigh County Prison Suicide Prevention Policy is unconstitutional because, contrary to the standards for prevention of custodial suicide established by the American Correctional Association, it does not make provision for the constant observation of suicidal inmates and does not require annual training for correctional officers on suicide prevention. Plaintiffs further assert that the Lehigh County Prison Suicide Prevention Policy is unconstitutional because, contrary to the standards for prevention of custodial suicide established by the National Commission on Correctional Health Care, it does not require uninterrupted monitoring or the transfer of an inmate to a medical facility and does not require a nearly suicide proof cell.

However, the American Correctional Association and the National Commission on Correctional Health Care standards relied upon by the Plaintiffs are not governmental standards or requirements. They are nothing more than recommendations of private organizations in the corrections field that seek to provide accreditation services to jails and prisons. The failure of a correctional facility to comply with the recommended standards means only that the correctional facility would not receive accreditation by the organization in question. At best, noncompliance with the recommended standards could possibly be used to suggest negligence. But as all of the prison suicide cases

make clear, negligence on the part of the prison officials is insufficient to impose liability.[15]

Indeed, in the instant case, there is a dearth of evidence to demonstrate that the relevant policies, practices and customs of Lehigh County Prison constitute deliberate indifference with respect to the decedent's suicide.[16] Similarly, the record is absent of proof that any one on the staff of Lehigh County Prison was deliberately indifferent to the suicide of the decedent, i.e., subjectively disregarding the decedent's suicide risk. *See Farmer*, 511 U.S. at 837, 114 S.Ct. at 1979. In fact, the customs and policies of the Lehigh County Prison meet the National Commission on Correctional Heath Care's Suicide Prevention Standards, and there was no pattern of suicide at Lehigh County Prison prior to the decedent's death to indicate that Lehigh County Prison's suicide prevention policies were problematic.

Based on the foregoing, it is clear that the County of Lehigh and its supervisors had not deliberately chosen to allow suicides, perpetrated a custom of

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[15]Of importance, violation of a recommended standard or failure to adopt a particular standard does not equate to a violation of the constitution so as to support a 42 U.S.C.A. § 1983 claim. *See Bell v. Wolfish*, 441 U.S. 520, 543 (1979).

[16] In order to impose liability on the County of Lehigh, Plaintiffs must present evidence of deliberate indifference on the part of the official or officials with the authority to make municipal policy. *Simmons v. Philadelphia*, 947 F.2d 1042, 1059-1065 (3rd Cir. 1991). The Plaintiffs must show deliberate indifference on the part of a high level official determined by the court to have final policymaking authority in the areas in question. Id., at 1062-1063.

inaction or communicated tacit approval of or acquiescence to inmates' suicides. Rather, express policies were implemented, such as the removal of excess clothing and the checking on inmates at certain intervals to prevent these incidents. Accordingly, summary judgment is appropriate.

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Supreme Court, U.S.
FILED

(2) 071361 APR 25 2008

OFFICE OF THE CLERK

No. _____

In the Supreme Court of the United States

RUTH AROCHO, As Administratrix of the ESTATE OF ENRIQUE RENE VERAS, WADAYS VERAS, and RUTH AROCHO As Parent and Natural Guardian of Crystal Veras,and Yashora Veras
Petitioners

-vs-

COUNTY OF LEHIGH and DALE MEISEL,
Respondents

On Petition for Writ of Certiorari to
The Supreme Court of Pennsylvania

APPENDIX VOLUME II
(Pages 64-147)

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BEST AVAILABLE COPY

SECTION 5 - MEDICAL SERVICES

UBJECT: Suicide Prevention

URPOSE: To provide written procedures regarding Lehigh County Prison's suicide prevention program in order to protect inmates from self-harm or death.

PPLICABILITY: This policy applies to staff and inmates at Lehigh County Prison.

OLICY: It is the policy of Lehigh County Prison to provide special housing, increased levels of observation, and medical restraint to those inmates who display self-destructive behavior.

EFERENCES: National Commission on Correctional Health Care (NCCHC) Standards for Health Services in Jails 1996-J-05, J-10, J-51

ACA-3-ALDF-4E-11
ACA-3-ALDF-4E-12
ACA-3-ALDF-4E-16
ACA-3-ALDF-4E-20
ACA-3-ALDF-4E-32
ACA-3-ALDF-4E-34
ACA-3-ALDF-4E-37
ACA-3-ALDF-4E-38

37 PA Code 95.232

PA Mental Health Act of 1976

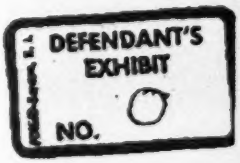
ROCEDURE:

IDENTIFICATION & REFERRALS:

A. As part of the Initial Receiving Screen, Registered or Licensed Practical Nurses shall evaluate all inmates for suicide risk.

B. Any inmate who expresses suicidal ideation or behaviors to a staff member shall be immediately referred to medical staff.

C. The referring staff person shall generate an incident report, and the Shift Commander shall forward a copy to the medical department.



2. ASSESSMENT AND COMMUNICATION:

A. A nurse or psychiatrist will evaluate any inmate who has been identified as a potential suicide risk.

B. If the evaluator concludes that the inmate requires an increased level of care, the disposition may include close observations, suicide precautions or medical restraint.

C. The disposition shall be communicated to the Housing Unit Officer by phone.

D. Medical staff shall complete the Medical Status Form including disposition and level of monitoring required. A copy of the form shall be distributed to the Shift Commander, Treatment Department and Housing Unit Officer.

E. In the case of suicide precautions, the form must be immediately signed by the Shift Commander prior to distribution. The Shift Commander shall forward a copy to the Housing Unit Officer (see attachment #1).

F. The Medical Staff shall enter the disposition in the special needs computer program.

3. MONITORING AND HOUSING:

A. Levels of increased observation and care.

1) Close Observation:

a) Close observation includes a specified time interval for checking an inmate's behavior.

b) Close observation is documented by the Housing Unit Officer on the Psychiatric Check Report and submitted to the Medical Department at the end of each shift.

c) Medical staff will review the check reports each shift for any significant changes in behavio (attachment #2).

2) Suicide Precaution: This involves the inmate in an open-barred cell for direct observation, removing the inmate's clothing and all other cell contents.

a) The Housing Unit Officer shall issue a heavy blanket in good structural condition to the inmate.

b) The Nurse shall place the inmate on Finger Foods/No Utensil status.

c) The Housing Unit Officer shall offer a daily shower to the inmate and directly supervise the inmat showering.

d) The Housing Unit Officer shall monitor the inmate at irregular fifteen-minute intervals (no mo than fifteen minutes between checks). The checks are staggered so that there is no predictabl pattern for the inmate to use in planning suicide.

e) The Housing Unit Officer shall document suicide checks on the psychiatric check form and subm it to the medical department at the end of each shift.

f) Medical staff will review the check report each shift for any significant changes in behavior.

g) Medical staff will have daily contact with the inmate.

h) In the event of an official visitor (i.e. attorney, parole official) the inmate will be dressed ar escorted to the appropriate visit area and remain under direct visual observation by the escortin officer.

3) Medical Restraints: Upon a physician's order, an inmate may be placed in the Restraint Chair (RC) if he or she exhibits extreme behavior potentially or actually harmful to self or others and no other less restrictive treatment is appropriate.

a) The RC is the only approved form of medical restraint.

b) Staff supervising the placing of an inmate into the Restraint Chair must be trained in its use.

c) Medical personnel must check the initial application of restraints to ensure circulation is not impaired.

d) The inmate will be dressed in clothing appropriate to temperature unless otherwise specified by the mental health order.

e) Medical staff shall make an assessment every two hours of the inmate's behavior, position, restraints, and health care needs (food, water, elimination and cleanliness) and ensure the needs are met.

f) The Housing Unit Officer shall monitor the inmate at irregular fifteen-minute intervals (no more than fifteen minutes between checks).

g) The Housing Unit Officer shall document medical restraint checks on a Psychiatric Check Report Form and submit them to the Medical Department at the end of each shift.

h) Medical staff will review the check report each shift for any significant changes in behavior.

i) The Housing Unit Officer shall document each time the inmate is released from medical restraints, or the reason for not releasing the restraints.

j) Medical restraint orders shall not exceed 24 hours.

k) Medical restraints shall not be removed without a physician's order with the following exception. The Housing Unit Officer shall remove the restraints every two hours for ten minutes unless the inmate is extremely agitated. The inmate must be monitored continuously when out of medical restraints.

B. Inmate Monitors

1) Inmate monitors may be assigned at the discretion of the medical staff to assist Correctional Staff in directly observing inmates who are on close observations, suicide precautions and medical restraints.

2) Inmate monitors do not relieve staff from their responsibility to check on the condition of the inmate.

Effective Date April 20, 2001

Edward G. Sweeney, Director

App. 67

STANDARDS FOR HEALTH SERVICES IN JAILS

NATIONAL COMMISSION ON
CORRECTIONAL HEALTH CARE

1996
Second Printing

DEFENDAN
EXHIBIT
NO. M 1

Discussion

An *infirmary* is an area within the confinement facility accommodating two or more inmates for a period of 24 hours or more, expressly set up and operated for the purpose of caring for patients who are not in need of hospitalization or placement in a *licensed nursing care facility*. *Infirmary care* is defined as inpatient bed care by or under the supervision of a registered nurse for an illness or diagnosis that requires limited observation and/or management but does not require admission to a licensed hospital or nursing care facility.

The determination of sufficient and appropriate health care personnel is based on the number of patients, the severity of their illnesses, and the level of care required for each and should be addressed in the staffing plan (see J-23). Being within sight or hearing of a health care staff person means that the inmate-patient readily can gain the person's attention. Call lights and buzzer systems are useful ways of ensuring this.

Advancement of the quality of care in this type of medical area begins with the assignment of responsibility to one physician. Depending upon the size of the infirmary, this physician may be employed part- or full-time.

Nursing care policies and procedures should be consistent with professionally recognized standards of nursing practice and in accordance with the nursing practice act and licensing requirements of the state. Policies and procedures should be developed on the basis of current scientific knowledge and take into account new equipment and current practices.

The inpatient record should include admitting notes, a discharge plan (see J-42 Continuity of Care) including a summary if the patient has been discharged, and complete documentation of the care and treatment given. If the inpatient record is retained separately from the outpatient record, a copy of the discharge summary from the inpatient facility should be placed in the inmate's outpatient chart.

A *licensed nursing care facility* provides long-term or rehabilitative care to patients with chronic physical or mental disabilities.

J-51 Suicide Prevention (essential)

Written policy and defined procedures require, and actual practice demonstrates, that the jail has a program for identifying and responding to suicidal individuals. The program components include identification, training, assessment, monitoring, housing, referral, communication, intervention, notification, reporting, review, and *critical incident debriefing*.

Discussion

While inmates may become suicidal at any point during their stay, high-risk periods include the time immediately upon admission to a facility (especially if inmates are intoxicated from alcohol or other drugs); after adjudication, when the inmate is returned to a facility from court; following the receipt of bad news regarding self or family (such as serious illness or the loss of a loved one); and after suffering some type of humiliation or rejection. Individuals who are in the early stages of recovery from severe depression may be at risk as well.

Key components of a suicide prevention program include the following:

1. Identification. The receiving screening form should contain observation and interview items related to the inmate's potential suicide risk (see the sample screening forms and guidelines in Appendix F).

2. Training. All staff members who work with inmates should be trained to recognize verbal and behavioral cues that indicate potential suicide. The plan should include initial and subsequent training.

3. Assessment. This should be conducted by a qualified mental health professional, who designates the inmate's level of suicide risk.

4. Monitoring. The plan should specify the facility's procedures for monitoring an inmate who has been identified as potentially suicidal. Regular, documented supervision should be maintained. (Refer to sample suicide precaution protocol in Appendix F for further discussion on monitoring.)

5. Housing. A suicidal inmate should not be housed or left alone. An appropriate level of observation must be maintained. If a sufficiently large staff is not available that constant supervision can be provided when needed, the inmate should not be isolated. Rather, s/he should be housed with another resident or in a dormitory and checked every 10-15 minutes. An inmate assessed as being a high suicide risk always should be observed on a continuing, uninterrupted basis or transferred to an appropriate health care facility. The room should be as nearly suicide-proof as possible (i.e., without protrusions of any kind that would enable the inmate to hang him/herself).

6. Referral. The plan should specify the procedures for referring potentially suicidal inmates and attempted suicides to mental health care providers or facilities.

7. Communication. Procedures should exist for communication between health care and correctional personnel regarding the status of the inmate (see J-60).

8. Intervention. The plan should address how to handle a suicide in progress, including appropriate first-aid measures.

9. Notification. Procedures should be in place for notifying jail administrators, outside authorities, and family members of potential, attempted, or completed suicides.

10. Reporting. Procedures for documenting the identification and monitoring of potential or attempted suicides should be detailed, as should procedures for reporting a completed suicide.

11. Review. The plan should specify the procedures for medical and administrative review if a suicide or a serious suicide attempt (as defined by the suicide plan) does occur.

12. *Critical incident debriefing.* Responding to and/or observing a suicide in progress can be extremely stressful for staff and inmates. The plan should specify the procedures for offering critical incident debriefing to all affected personnel and inmates.

J-52 Intoxication and Withdrawal (essential)

The responsible physician has approved written policy, procedures, and specific protocols for inmates under the influence of alcohol or other drugs or those undergoing withdrawal. Inmates experiencing severe intoxication (overdose) or withdrawal are immediately transferred to a licensed acute care facility. Established guidelines for the treatment and observation of individuals manifesting mild or moderate symptoms of intoxication or withdrawal from alcohol and other drugs are developed and followed. Individuals at risk for progression to more severe levels of intoxication or withdrawal are kept under constant observation by qualified health professionals or health-trained correctional officers. *Medical detoxification* is done only under medical supervision in accordance with local, state, and federal laws.

Discussion

Significant percentages of inmates admitted to correctional institutions have a history of alcohol or other drug abuse. Newly incarcerated individuals may enter intoxicated or develop symptoms of alcohol or other drug withdrawal. Alcohol withdrawal is the abstinence syndrome with the highest mortality rate, although opiate and tranquilizer withdrawal are, on occasion, life-threatening. Barbiturate withdrawal, while rare in

Wexford Health Sources, Inc.
Guidelines and Standards for Correctional Health Care - Jails

Suicide Prevention - Essential

Subject: Suicide Prevention; J-51.00

Purpose: To outline program to effectively address the risk of suicide within the inmate population.

Procedure:

1. Inmates will be evaluated for potential suicide risk at intake, as outlined in Policy 30.00, *Receiving Screening*.
2. Potentially suicidal inmates will be managed as outlined in Policy 51.01, *Management of Potentially Suicidal Inmates*.
3. Administrative review of completed suicides will be as outlined in Policy 10.00, *Procedures in the Event of an Inmate Death*.
4. Training of correctional staff in the identification and management of suicide risk will be as outlined in Policy 19.00, *Training for Correctional Officers*.
5. Since observing a suicide in progress can be extremely stressful for staff and inmates, critical incident debriefing measures will be offered to all responding health care personnel, as well as to observing inmates. The Health Care Unit Administrator shall appoint a health care staff member qualified to refer affected persons to a mental health professional.

References: National Commission on Correctional Health Care: Standards for Health Services in Jails, 1996 J-51
American Correctional Association, Standards for Adult Local Detention Facilities, 3rd Edition, 1991 3-4378-3A

Health Care Unit Administrator — Date: 8/16/01 3/13/02

Medical Director — Date: 8/2/01 3/13/02

Wexford Health Sources, Inc.
Guidelines and Standards for Correctional Health Care - Jails

Management of Potentially Suicidal Inmates

Subject: Suicide Prevention - Management of Potentially Suicidal Inmates; J-S1.01

Purpose: To establish guidelines and procedures to manage suicidal, or potentially suicidal inmates, consistent with security requirements and accepted mental health practices.

Policy: 1. Whenever an inmate demonstrates or reports a risk for self-destructive behavior, immediate assistance will be provided.

2. Precaution procedures will be implemented until evaluation by mental health staff.

3. Mental health evaluation will determine the subsequent actions needed to provide the inmate support and monitoring during critical period.

Procedure: 1. Institutional staff will be trained in the identification of potentially suicidal inmates. Signs of risk for self-destructive behavior include the following:

a. Inmate engages in, or attempts to engage in behavior with potential for self-harm (e.g., swallows razor blades, places plastic bag over head, self-mutilation).

b. Inmate threatens to attempt suicide.

Health Care Unit Administrator — Date 8/16/01 3/6/02

Medical Director — Date 8/24/01 3/13/02

Management of Potentially Suicidal Inmates (Continued)

Procedure:

c. Inmate talks about suicide or self-injurious behavior with staff or other inmate(s).

d. Inmate has a documented history of previous suicide attempt(s) or self-harm.

e. Inmate exhibits markedly sad, tearful behavior, or reduced emotional reactivity.

f. Inmate makes vague references to death.

g. Inmate exhibits dramatic shift from depression to elation, or agitated depression to calm.

h. Inmate appears withdrawn with minimal responding, typically in flat emotionless tone.

l. Inmate informed of significant family crisis (e.g., death of family member, divorce).

j. Inmate has recently been sentenced, or denied release.

k. Inmate has conflicting feelings about impending release.

2. Referral of Potentially Suicidal Inmate

a. Inmate who has attempted suicide will receive immediate medical attention. Once emergency medical treatment is completed, mental health staff will perform evaluation.

b. In all incidents of suicide, or suicidal attempts resulting in hospitalization, the Health Care Unit Administrator will be notified immediately.

c. Any staff member of the institution concerned that an inmate may be potentially suicidal will inform the medical staff immediately.

Management of Potentially Suicidal Inmates (Continued)

Procedure:

d. An inmate identified as potentially suicidal will be evaluated as soon as possible by mental health staff. Pending evaluation, the inmate will be kept under constant observation.

3. Evaluation of Potentially Suicidal Inmate

a. Evaluation by mental health staff will include, but not be limited to the assessment of the following:

1. Inmates mental status
2. Inmates self-report or behavior resulting in referral
3. Current suicidal risk (ideation, plans, lethality of plan, recent stressors, goal or behavior)
4. History of suicidal behavior / ideation, how often, when, method used or contemplated, why, consequences of prior attempts / gestures
5. Inmates report of his/her potential for suicidal behavior

b. Mental health staff will consult with psychiatrist to assist in evaluation if needed.

c. Whenever mental health staff feels unable to make judgment of current suicide potential, the inmate will be managed as potentially suicidal.

4. Disposition

a. If mental health staff determines that suicide threat was issued as a manipulative gesture, inmate presents no evidence of psychological distress, and inmate denies current suicidal ideation / intention, the inmate will be returned to housing unit with recommendation that mental health staff be contacted if needed.

b. If mental health staff determines that inmate is depressed and/or anxious, but not an actual suicide risk, the inmate will be counseled and returned to housing unit. Inmate will be monitored by mental health staff until the presenting symptoms have remitted.

Management of Potentially Suicidal Inmates (Continued)

c. If mental health staff determines that inmate is in danger of immediate or delayed self-harm, the inmate will be place under suicide precautions.

5. Precautions for potentially suicidal inmate.

a. Inmate will be placed in area designated by security to permit close observation. If constant observation cannot be maintained, inmate will be place in area with other inmates, but having restricted access to instruments for self-harm.

b. If a stripped cell is used for close observation, security staff will inspect cell prior to inmate placement to ensure no items available for potential self-harm.

c. Inmate will only be allowed personal property appropriate to level of suicidal potential. If risk of suicide is clear and immediate, inmate will be stripped of all clothing and issued one blanket.

d. Inmate who is engaging in self-injurious behavior after placement in seclusion cell will be considered for transfer to inpatient psychiatric setting.

e. Inmate will be observed at least every shift by the nursing staff. These observations will be documented by completion of Mental Health Observation form.

f. Inmate in suicide precaution status will be evaluated daily by medical staff, or psychiatrist when available. Staff will consider transfer to an inpatient psychiatric setting if suicide potential persists.

References National Commission on Correctional Health Care. Standards for Health Services in Jails, 1996. J-51.
American Correctional Association: Standards for Adult Local Detention Facilities, 3rd Edition, 1991. 3-ALDF-4E-34.

ASSESSMENT OF *AROCHO v. LEHIGH COUNTY, ET. AL.*

Introduction

Detailed below is this writer's assessment of the above captioned case. Such assessment is based upon review of documents supplied to date and identified below. As such, this writer reserves the option of amending and/or enlarging upon this assessment if subsequent documents become available.

By way of background, this writer is a project director of the National Center on Institutions and Alternatives, with an office in Mansfield, Massachusetts. A nationally recognized expert in the field of suicide prevention in correctional facilities, this writer has served as project director for the *only* four national U.S. Justice Department-funded studies of jail, prison, and juvenile suicide. Since 1986, this writer has also served as editor and project director for the *Jail Suicide/Mental Health Update* newsletter, a quarterly publication devoted to research, training and prevention that is funded by the U.S. Justice Department. This writer has authored over 60 other publications in the area of suicide prevention in jail, prison, and juvenile facilities. These publications are listed in the curriculum vitae attached as Exhibit 1.

In addition, since 1983, this writer has served as a consultant in providing staff training and program assessment/development services in the area of suicide prevention in correctional facilities to numerous local and state jurisdictions throughout the country. This writer also serves as the suicide prevention consultant to the Special Litigation Section of the U.S. Justice Department's Civil Rights Division in its investigation of conditions of confinement in various correctional facilities; serves as an expert consultant to court systems in the development and monitoring of jail

and juvenile suicide prevention programs; and serves as a consultant to several state departments of correction and state juvenile correctional agencies in the area of suicide prevention. Further, this writer has served as an expert witness/consultant in over 240 litigation cases involving suicide in correctional facilities, and has been qualified as an expert in both federal and state courts throughout the country.

This writer was a recent past recipient of the National Commission on Correctional Health Care's Award of Excellence for outstanding contribution in the field of suicide prevention in correctional facilities. This writer's work has been cited in the suicide prevention sections of various state and national correctional health care standards, and training curricula has been utilized by hundreds of correctional agencies throughout the country.

Finally, as a result of research, technical assistance, and consultant work in the area of suicide prevention in correctional facilities, this writer has reviewed and/or examined over 1,500 cases of suicide in jail, prison, and juvenile facilities throughout the country during the past 25 years.

Documents Reviewed

The following documents were reviewed in preparation of this assessment. They include: Complaint in Civil Action; Answer and New Matter; Plaintiffs' Answer to Defendants' New Matter; Defendants' Response to Plaintiffs' First Request for the Production of Documents; Defendants' Answers to Plaintiffs' Expert Interrogatories; Defendants' Response to Plaintiffs' First Set of Interrogatories; various arrest and Lehigh County Prison records of Enrique Veras; various

medical and mental health records of Mr. Veras while he was confined in the Lehigh County Prison incident reports/statements written by various Lehigh County Prison personnel regarding Mr. Veras suicide attempts in the Lehigh County Prison on February 10, February 11, March 30, October 2 October 28 and December 4, 2002, as well as his suicide on December 5, 2002; DVD/videotape recording of Mr. Veras' housing unit during the afternoon of December 5, 2002; lesson plan an class rosters of Lehigh County Prison's suicide prevention training from 1995 thru 2002; inciden reports regarding a prior inmate suicide and prior inmate suicide attempts in the Lehigh Count Prison; various Lehigh County Prison policies, including suicide prevention, inmate monitor health care, and use of force and application of restraints; and deposition transcripts of Dal Albright, John Donate, David Dreisbach, David Eitemiller, Ronald Kiefer, Clifford Knappenberge Robert McFadden, Dale Meisel, Nelson Santiago, Garry Stemz, Edward Sweeney, Alex Thomas MD, Gregory Thomas, John Urban, and Tyrone Wright.

Finally, this writer has relied upon the Commonwealth of Pennsylvania's *Title 37, Chapte 95. County Correctional Institutions*; the American Correctional Association (ACA)'s *Standard for Adult Local Detention Facilities*, Third Edition (1991) and pertinent Supplements; as well as th National Commission on Correctional Health Care (NCCHC)'s *Standards for Health Services i Jails* (1996).

Case Analysis

The Complaint contains several allegations that the Defendants displayed both negligenc and deliberate indifference to Enrique Veras, the proximate result of which was his suicide in th Lehigh County Prison on the afternoon of December 5, 2002. This writer was asked by plaintiff

counsel to examine the Complaint, as well as pertinent documents available in this case to date, and give an opinion as to whether, through policy and practice, the actions and/or inactions by the Defendants were either contrary or inconsistent with both national jail standards and standard correctional practice, and were the proximate causes of Mr. Veras' death.

According to available records, 45-year-old Enrique Versa was first confined in the Lehigh County Prison on February 8, 2002 for various charges, including alleged criminal attempt at kidnapping, unlawful restraint, and aggravated assault. He was assessed as being both mentally ill and suicidal soon after his confinement. During the intake process, Mr. Veras became incoherent and it was determined that he had suffered from an overdose of his psychotropic medication. A razor blade was later found in his clothes. Mr. Veras was placed on suicide precautions with the requirement of observation at 15-minute intervals. Two days later on February 10, he was observed to be bleeding from self-inflicted lacerations on his right wrist. He was provided treatment by nursing staff and remained on suicide precautions with observation at 15-minute intervals. The following day (February 11), Mr. Veras was observed with a noose around his neck and tied to the cell bars. The ligature was removed and he remained on suicide precautions. On March 30, he was again placed on suicide precautions with the requirement of observation at 15-minute intervals for self-injurious behavior. Mr. Veras was released from the Lehigh County Prison on April 2, 2002.

Mr. Veras was again confined in the Lehigh County Prison on October 27, 2002 for charges that included alleged aggravated assault and reckless endangerment. At the scene of arrest, he threatened suicide by placing a knife to his throat. He also appeared depressed ("feeling so bad") and threatened suicide ("can't live anymore") during the intake process. Mr. Veras self-reported a

history of mental illness, psychiatric hospitalization, and psychotropic medication. He also ha observable scars from previous self-inflicted injuries. He was placed on suicide precautions in th reception unit (1D2) with the requirement of observation at 15-minute intervals. Several hours late Mr. Veras began to engage in self-injurious behavior by repeatedly throwing himself on the floo and wall of his cell causing head trauma, and was placed in a restraint chair and receive psychotropic medication. He continued to be observed as "quite tearful and depressed." Mr. Vera was subsequently removed from the restraint chair but remained on suicide precautions with th requirement of observation at 15-minute intervals. The following day (October 28), Mr. Veras wa found hanging from the cell bars by a blanket that he had torn into strips. Although the arrivin nurse declared that "he's gone," Mr. Veras remained conscious and was placed in a restraint cha after continuing to threaten suicide. He was subsequently released from the restraint chair an remained on suicide precautions. On November 4, Mr. Veras was relocated to the mental health uni (1D1) and remained on suicide precautions until November 14. Although Mr. Veras remaine housed in the mental health unit, as a result of his suicidal behavior, as well as assaultive behavior t staff, he was punished by receiving a sanction of disciplinary segregation.

During the evening of December 4, 2002, Mr. Veras was requested to change cells in th mental health unit. He refused, became very agitated and was forcefully removed from the unit an relocated in the segregation unit (3C1) at approximately 8:50pm. Upon placement in hi segregation cell, Mr. Veras remained agitated and began to engage in various forms of self-injurio behavior, including banging his head against the floor, bunk and wall; climbing on the top bunk an purposely falling off to the concrete floor; attempting to flush is head down the toilet; and trying t

hang himself by tying his underwear around his neck and to the towel bar in the cell. He was again placed in a restraint chair.

A few hours later at approximately 12:30 am on December 5, 2002, Mr. Veras was released from the restraint chair and placed on suicide precautions with the requirement of observation at 15-minute intervals. For unexplained reasons, he was reportedly observed at 30-minute intervals during the next several hours. Beginning at approximately 7:30am, the officers' logs reflected observation at exact 15-minute intervals. The last documented observation of Mr. Veras on suicide precautions occurred at 4:00pm on December 5, 2002. At approximately 4:16pm, a correctional officer found Mr. Veras hanging from the cell bars by strip of bed sheet. (According to the videotape recording of the housing unit and the suicide attempt, the last time that an officer was in the housing unit was approximately 3:45pm and that officer did not walk past Mr. Veras' cell. Mr. Veras is seen on the videotape to be tying the sheet to the cell bars at 3:56pm and the sheet is visible from that time forward until he was found hanging 20 minutes later at 4:16pm.) The officer called for back-up personnel and several correctional staff arrived shortly thereafter and assisted in cutting the sheet away from the bars. The cell door was opened and Mr. Veras was placed on the floor. Other correctional personnel arrived in the housing area and stood around the victim. Approximately two minutes later at 4:19pm, medical staff arrived and initiated cardiopulmonary resuscitation. At approximately 4:29pm, emergency medical services personnel arrived and continued life-saving measures. Mr. Veras was then transported to a local hospital and subsequently pronounced dead.

Opinions

Based upon review of the case file materials and above summary, this writer offers the following opinions. *First*, there was overwhelming evidence to show that Enrique Veras was at a continuing high risk for suicide in the Lehigh County Prison, and that continuing high risk was known to the defendants and various personnel. *Second*, the Lehigh County Prison had grossly inadequate policies and practices in the area the suicide prevention (particularly levels of observation and safe housing) that were the proximate causes of Mr. Veras' suicide because it was reasonable to assume that the provision of grossly inadequate supervision for continuing high risk suicidal behavior, as well as placement in a dangerous cell, would ultimately result in his suicide. The basis for these opinions is offered below.

1) **Notice of Continuing High Suicide Risk**

There was overwhelming evidence to show that Enrique Veras was at a continuing high risk for suicide in the Lehigh County Prison, and that continuing high risk was known to the Defendants and various personnel. Prison officials and staff disregarded this obvious high risk by failing to take appropriate steps to ensure Mr. Veras' safety during his periodic confinement in the Lehigh County Prison from February 8 thorough December 5, 2002. Such action (or inaction) was completely unreasonable and lacked common sense.

Mr. Veras' continuing high risk for suicide during his confinement in the Lehigh County Prison was graphically exemplified by the following known facts: 1) he had a history of mental illness, psychiatric hospitalization, and psychotropic medication; 2) he was observed to be depressed, agitated, incoherent, "quite tearful" and crying, and displaying numerous self-inflicted

injuries and scars; 3) he self-reported both depression ("feeling so bad") and suicidal ideation ("can't live anymore"), as well as requested to remain in the restraint chair when feeling the impulse to engage in suicidal behavior; and 4) engaged in self-injurious behavior on a least seven separate occasions (immediately prior to or) during his confinement:

- upon intake on February 8 when it was suspected that he overdosed on psychotropic medication,
- on February 10 when he was observed to be bleeding from lacerations on his right wrist,
- on February 11 when he was observed with a noose around his neck and tied to the cell bars,
- on March 30 when he was observed engaging in self-injurious behavior,
- on October 27 when he repeatedly threw himself on the floor and wall of his cell causing head trauma,
- on October 28 when he was found hanging from the cell bars by a blanket that he had torn into stripe, and
- on December 4, 2002 when he observed banging his head against the floor, bunk and wall; climbing on the top bunk and purposely falling off to the concrete floor; attempting to flush is head down the toilet; and trying to hang himself by tying his underwear around his neck and to the towel bar in the cell.

Despite Enrique Veras' continuing high risk for suicide during his confinement in the Lehigh County Prison, the response from the Defendants and staff was the following: placement on suicide precautions in various unsafe cells with the requirement of observation that did not include constant observation (see below), periodic assessment by contracted medical and mental health staff, psychotropic medication, and periodic placement for a few hours in a restraint chair. These responses were grossly inadequate because Mr. Veras was permitted to continue to engage in self-injury and ultimately committed suicide in the facility

2) **Grossly Inadequate Policies and Practices**

The Lehigh County Prison had grossly inadequate policies and practices in the area of suicide prevention (particularly levels of observation and safe housing) that were the proximate causes of Mr. Veras' suicide. A written suicide prevention policy is a prerequisite for running a correctional facility. The importance of written policy in suicide prevention is clearly stated in the American Correctional Association (ACA)'s *Standards for Adult Local Detention Facilities* (3-ADLF-4E-34): "There is a written suicide prevention and intervention program that is reviewed and approved by a qualified medical or mental health professional."[1] In addition, the National Commission on Correctional Health Care (NCCHC)'s *Standards for Health Service in Jails* (J-31) requires each jail to have a written suicide prevention plan that includes the following components: identification, training, assessment, monitoring, housing, referral, communication, intervention, notification, reporting and review.[2]

The Lehigh County Prison's suicide prevention policy (No. 5.5, effective April 20, 2001) states that the facility will "provide special, housing, increased levels of observation, and medical restraint to those inmates who display self-destructive behavior." The policy references both ACA and NCCHC standards, and Dale Meisel, warden of the Lehigh County Prison, and Edward Sweeney, director of corrections for Lehigh County, both testified in their respective depositions that the suicide prevention policy was largely based upon ACA and NCCHC standards. Yet

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[1] American Correctional Association (1991), *Standards for Adult Local Detention Facilities* (3rd Edition), Lanham, MD: Author.
[2] National Commission on Correctional Health Care (1996), *Standards for Health Services in Jails* (3rd Edition), Chicago, IL: Author.

although Policy 5.5 includes provisions for identification, assessment/ communication, and observation, it is not consistent with ACA and NCCHC standards and is grossly inadequate.

For example, ACA standard 3-ALDF-3D-08 states that:

> Written policy, procedure, and practice require that all special management inmates are personally observed by a correctional officer at least every 30 minutes on an irregular schedule. Inmates who are violent or mentally disordered or who demonstrate unusual or bizarre behavior receive more frequent observation; *suicidal inmates are under continuous observation* (emphasis added)

In addition, ACA standard 3-ALDF-4E-34 states that:

> There is a written suicide prevention and intervention program that is reviewed and approved by a qualified medical or mental health professional. All staff with responsibility for inmate supervision are trained in the implementation of the program.
>
> Comment: The program should include specific procedures for intake screening, identification, and supervision of suicide-prone inmates.

Finally, ACA standard 3 ALDF 1D 12 states that all correctional staff are required to have *annual* instruction in suicide prevention ("signs of suicide risk" and suicide precautions").

The Lehigh County Prison's suicide prevention policy is also in violation of NCCHC standards. For example, NCCHC's suicide prevention standard (J-51) requires the following:

> **1) Identification.** The receiving screening form should contain observation and interview items related to the inmate's potential suicide risk.
>
> **2) Training.** All staff members who work with inmates should be trained to recognize verbal and behavioral cues that indicate potential suicide. The plan should include initial and subsequent training.

3) Assessment. This should be conducted by a qualified mental health professional, who designates the inmate's level of suicide risk.

4) Monitoring. The plan should specify the facility's procedures for monitoring an inmate who has been identified as potentially suicidal. Regular, documented supervision should be maintained.

5) Housing. A suicidal inmate should not be housed or left alone. An appropriate level of observation must be maintained. If a sufficiently large staff is not available that constant supervision can be provided when needed, the inmate should not be isolated. Rather, s/he should be housed with another resident or in a dormitory and checked every 10-15 minutes. *An inmate assessed as being a high suicide risk always should be observed on a continuing, uninterrupted basis or transferred to an appropriate health care facility. The room should be as nearly suicide-proof as possible (i.e., without protrusions of any kind that would enable the inmate to hang him/herself).* (Emphasis added)

6) Referral. The plan should specify the procedures for referring potentially suicidal inmates and attempted suicides to mental health care providers or facilities.

7) Communication. Procedures should exist for communication between health care and correctional personnel regarding the status of the inmate.

8) Intervention. The plan should address how to handle a suicide in progress, including appropriate first-aid measures.

9) Notification. Procedures should be in place for notifying jail administrators, outside authorities, and family members of potential, attempted, or completed suicides.

10) Reporting. Procedures for documenting the identification and monitoring of potential or attempted suicides should be detailed, as should procedures for reporting a completed suicide.

11) Review. The plan should specify the procedures for medical and administrative review if a suicide or a serious suicide attempt (as defined by the suicide plan) does occur.

12) Critical incident debriefing. Responding to and/or observing a suicide in progress can be extremely stressful for staff and inmates. The plan should specify the procedures for offering critical incident debriefing to all affected personnel and inmates.

The Lehigh County Prison's suicide prevention policy provides two levels of observation for suicidal inmates: *suicide precaution* and *close observation*. According to both the policy and deposition testimony in this case, there is little discernable difference between the two supervision levels. In practice, inmates on *suicide precaution* status are stripped naked of their clothing, all items (with the exception of a blanket) are removed from the cell, and they are observed "at irregular 15-minute intervals (no more than 15 minutes between checks). The checks are staggered so that there is no predictable pattern for the inmate to use in planning suicide." Inmates on *close observation* status are allowed to retain their clothing and other possessions and are observed at staggered 15-minute intervals. (It should be noted that, contrary to Lehigh County Prison policy, Mr. Veras was observed for several hours on December 5 at 30-minute intervals, and was rarely observed at staggered or "irregular" 15-minute intervals while on either close observation or suicide precaution status. Instead, the officers' logs were recorded at exact 15-minute intervals.)

Most importantly, according to the suicide prevention policy and deposition testimony of most deponents, both the policy and the practice of the Defendants was not to provide *constant observation* to high risk suicidal inmates (i.e., "*under continuous observation*" per ACA standards or "*on a continuing, uninterrupted basis*" per NCCHC standards) confined within the Lehigh County Prison.

As exemplified in Mr. Veras' case, the placement of an inmate identified as a continuing high risk for suicide on an observation level requiring supervision at 15-minute intervals is grossly inadequate and contrary to national correctional standards and standard correctional practices that

require constant observation and consideration for hospitalization. Observation at 15-minute intervals is routinely reserved for inmates assessed as being either at low or moderate risk for suicide. It defies common sense to expect that observation at 15-minute intervals will successfully thwart the suicide attempts of a highly suicidal individual.

In fact, the Lehigh County Prison was emphatically warned of Mr. Veras' high risk suicidal behavior when, upon his discharge from the emergency room of Sacred Heart Hospital on October 27, 2002, the physician stated: "BE ABSOLUTELY WATCHFUL OF HIS BEHAVIOR CONSIDER THIS PATIENT HIGH RISK FOR REPEATED SELF-INJURY. MUST HAVE SOMEONE WATCHING HIM AT ALL TIMES." A review of all available records in this case indicates that the defendants and their staff never placed Mr. Veras on constant observation nor considered psychiatric hospitalization for his continuing high risk suicidal behavior. Such inaction was unconscionable because it was reasonable to assume that the provision of grossly inadequate supervision for continuing high risk suicidal behavior would ultimately result in his suicide.

Further, the deposition testimony in this case revealed that even the alleged observation of Mr. Veras at 15-minute intervals was not always performed by an officer physically walking past his cell, but rather by an officer stationed inside the control booth which was estimated to be between 30 and 40 feet from Mr. Veras' cell and partially obstructed by the stairway. Alec Thomas, MD, a consulting psychiatrist to the Lehigh County Prison, stated in his deposition (at pages 32-33) that it would be improper for a control booth officer to be responsible for the observation of suicidal inmates, and that he was unaware that such a practice was occurring at the Lehigh County Prison.

As previously stated, the last time that an officer was in Mr. Veras' housing unit on December 5 was at approximately 3:45pm and that officer did not walk past Mr. Veras' cell. Mr. Veras can be seen on the videotape to be tying the sheet to the cell bars at 3:56pm and the sheet is visible from that time forward until he was found hanging 20 minutes later at 4:16pm. It is obvious that none of the officers assigned to the housing unit (including the control officer) adequately observed Mr. Veras prior to his death, the proximate cause of which was his ability to successfully commit suicide. In essence, had the Defendants and their staff followed standard correctional practices and national correctional standards, Mr. Veras would have been observed on constant observation following his most recent high risk self-injurious behavior on December 4 and not had the ability to successfully commit suicide on December 5, 2005.

With regard to housing of suicidal inmates, consistent with national correctional standards and standard practices in correctional facilities throughout the country, housing assignments should be based on the ability to maximize staff interaction with the inmate, avoiding assignments that heighten the depersonalizing aspects of incarceration. Ideally, suicidal inmates should be housed in the general population, mental health unit, or medical infirmary, located close to staff. All cells designated to house suicidal inmates should be suicide resistant, free of all obvious protrusions, and provide full visibility. These cells should contain tamper-proof light fixtures and ceiling air vents that are protrusion-free. No cell housing a suicidal inmate should have open-faced bars. Rather, each cell door should contain a heavy gauge Lexan (or equivalent grade) glass panel that is large enough to allow staff a full and unobstructed view of the cell interior. Cells housing suicidal inmates should not contain any electrical switches or

outlets, bunks with holes and ladders, towel racks on desks and sinks, radiator vents, corded telephones of any length, clothing hooks (of any kind), or any other object that provides an easy anchoring device for hanging. As reiterated in the NCCHC standards, "The room should be as nearly suicide-proof as possible (i.e., without protrusions of any kind that would enable the inmate to hang him/herself)."

Although Lehigh County Prison's suicide prevention policy requires "special housing" for suicidal inmates, the policy did not contain any description as to the type of housing provided to such inmates. According to the deposition testimony in this case, suicidal inmates can be placed in a variety of housing units in the Lehigh County Prison. According to the records, none of these placements provided safe housing for suicidal inmates because, at a minimum, they contain open-faced bars, shelves with clothing hooks, metal bunks, and towel racks attached to desks. In Mr. Veras' case, he was placed on suicide precautions in the reception, mental health and segregation units, and he was able to attempt suicide in each of these units. For example, he was found hanging from the cell bars in the reception unit on October 28, tried to hang himself from the towel bar attached to the desk in his cell in the segregation unit on December 4, and successfully committed suicide by hanging himself from the cell bars the following day on December 5. For inexplicable reasons, Mr. Veras was also able to attempt (and commit) suicide with ligatures that were prohibited from being in his cell, including a blanket and sheet.

Given the fact the inmates have historically attempted and/or committed suicide in the Lehigh County Prison utilizing a variety of dangerous anchoring devices (including a successful suicide by hanging of an inmate utilizing a shelf with clothing hooks in July 1995 and a hanging

attempt of a inmate utilizing the open-faced bars in February 2000), it is particularly troubling that Mr. Veras was placed in a cell on suicide precautions that contained protrusions that were obvious and previously known to be dangerous by the Defendants. Also troubling was the fact that Edward Sweeney, I.C.P. Director of Corrections, stated in his deposition (at pages 79-80) that Mr. Veras was placed in a cell that was not safe for housing suicidal inmates and that there were not any suicide-resistant cells in the facility (at pages 82-83). In fact, the Defendants promulgated a suicide prevention policy that required a suicidal inmate to be placed in a dangerous cell (i.e., "Suicide Precaution: This involves the inmate in an open-barred cell"), and Director Sweeney admitted during his deposition that Mr. Veras' cell door "obviously is not suicide-proof in that someone could certainly tie something to the door" (at page 80).

When questioned during their respective depositions regarding why Lexan paneling was not installed on the barred doors of cells housing suicidal inmates, Messrs. Meisel and Sweeney offered similarly inadequate responses, ranging from not having heard of Lexan paneling to the belief that inmates would smear feces on the paneling thus obstructing visibility. Yet heavy gauge Lexan (or equivalent grade) glass paneling is commonly known and utilized in jail and prison facilities throughout the country to cover bars of cells housing suicidal inmates. The Defendants had several options to house suicidal inmates in safe cells, including the placement of heavy gauge Lexan (or equivalent grade) glass paneling on selective cells utilized to house suicidal inmates, housing suicidal inmates in cells that did not have open-barred doors, and ensuring that suicidal inmates were provided with constant observation of a correctional officer who was stationed directly outside the cell. The Defendants chose none of these or other options

and simply continued to allow these obviously dangerous cells to be utilized for housing suicidal inmates.

Finally, this writer has reviewed Lehigh County Prison's 4-hour "In-Custody Suicide Prevention" training lesson plan developed in 1999. Overall, the lesson plan is very good and based in large part on this writer's suicide prevention training curricula. However, a review of the Class Roster revealed that the workshop for in-service suicide prevention training was offered at 1-hour, not 4-hour, durations. In addition, as shown below, contrary to both ACA and NCCHC standards, the Class Roster indicated that the 14 Lehigh County Prison personnel who were deposed in this case either never received suicide prevention training or received it infrequently from 1995 through 2002:

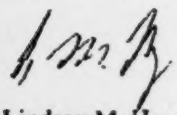
- Dale Albright – no training
- John Donate – no training
- David Dreisbach – received training March 1995 and November 1998
- David Eitemiller – received training May 2001
- Ronald Kiefer – received training September 1998 and April 1999
- Clifford Knappenberger – no training
- Robert McFadden – received training November 1998
- Dale Meisel – no training
- Nelson Santiago – received training May 1997, October 1999 and April 2002
- Garry Stercz – received training October 1996 and October 1999
- Edward Sweency – no training
- Gregory Thomas – no training
- John Urban – received training October 1999
- Tyrone Wright – received training July 1996 and April 1999

Summary and Conclusions

In summary, it would be this writer's opinion that: 1) there was overwhelming evidence to show that Enrique Veras was at a continuing high risk for suicide in the Lehigh County Prison, and that continuing high risk was known to the Defendants and various personnel: 2) despite knowledge that Mr. Veras was a continuing high risk for suicide, the Defendants and various personnel never placed Mr. Veras on constant observation nor considered psychiatric hospitalization; 3) the Defendants had grossly inadequate policies and practices in the area of suicide prevention (particularly levels of observation and safe housing) that were the proximate causes of Mr. Veras' suicide because it was reasonable to assume that the provision of grossly inadequate supervision for continuing high risk suicidal behavior, as well as placement in a dangerous cell, would ultimately result in his suicide; and 4) the Defendants' actions and inactions in not taking adequate precautions to manage Mr. Veras' continuing high risk for suicide reflected both negligence and deliberate indifference to his health and safety.

In conclusion, the suicide of Enrique Veras in the Lehigh County Prison on December 5, 2002 was among a handful of the worst cases that this writer has reviewed during the past 25 years. His death was clearly preventable and the actions/inactions displayed by the Defendants and various personnel can only be described as unconscionable.

Respectfully Submitted By:



Lindsay M. Hayes
October 31, 2005

EXHIBIT 1

VITAE

LINDSAY M. HAYES

PERSONAL INFORMATION

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ACADEMIC BACKGROUND

Master of Science – Administration of Justice (1978); The American University, Washington, D.C.

Bachelor of Arts – Sociology (1977); Ithaca College, New York

SUMMARY

Lindsay M. Hayes is a Project Director of the National Center on Institutions and Alternatives, with an office in Mansfield, Massachusetts. He is nationally recognized as an expert in the field of suicide prevention within jails, prisons and juvenile facilities. Mr. Hayes serves as a technical assistance consultant/expert by conducting training seminars and assessing inmate and juvenile suicide prevention practices in various state and local jurisdictions throughout the country.

Mr. Hayes has conducted the only four national studies of jail, prison, and juvenile suicide (*And Darkness Closes In...National Study of Jail Suicides* in 1981, *National Study of Jail Suicides: Seven Years Later* in 1988, *Prison Suicide: An Overview and Guide to Prevention* in 1995, and *Juvenile Suicide in Confinement: A National Survey* in 2004). The jail and prison suicide studies were conducted through contracts with the National Institute of Corrections (NIC), U.S. Justice Department; whereas the first national study of juvenile suicide in confinement was conducted through a contract with the Office of Juvenile Justice and Delinquency Prevention, U.S. Justice Department.

Mr. Hayes has acted as an expert witness/consultant in over 240 suicide litigation cases, as well as appointed to assist special masters in the development and implementation of suicide prevention policies in several adult and juvenile correctional systems under court jurisdiction. He is also a suicide prevention consultant to the U.S. Justice Department's Civil Right Division (Special Litigation Section) in its investigations of conditions of confinement in both adult and juvenile correctional facilities throughout the country.

Mr. Hayes serves as editor/project director of the *Jail Suicide/Mental Health Update*, a quarterly newsletter devoted to research, training, prevention, and litigation that is funded by NIC; and is a consulting editor and editorial board member of *Suicide and Life-Threatening Behavior*, the official scientific journal of the American Association of Suicidology, as well as editorial board member of *Crisis: The Journal of Crisis Intervention and Suicide Prevention*.

the official scientific journal of the International Association of Suicide Prevention. Mr. Hayes has authored over 50 publications in the area of suicide prevention within jail, prison and juvenile facilities, including model training curricula on both adult inmate and juvenile suicide prevention.

As a result of research, technical assistance, and expert witness consultant work in the area of suicide prevention in correctional facilities, Mr. Hayes has reviewed and/or examined over 1,500 cases of suicide in jail, prison, and juvenile facilities throughout the country during the past 24 years. In 2001, Mr. Hayes was presented with the National Commission on Correctional Health Care's Award of Excellence for outstanding contribution in the field of suicide prevention in correctional facilities. His work has been cited in the suicide prevention sections of various state and national correctional health care standards.

IN THE COURT OF COMMON PLEAS OF LEHIGH COUNTY, PENNSYLVANIA
CIVIL DIVISION – LAW

RUTH AROCHO, As Administratrix of the ESTATE OF ENRIQUE RENE VERAS and WADAYS VERAS and RUTH AROCHO as Parent and Guardian of CRYSTAL VERAS and YASHERA VERAS	:	**No.: 2003-C-3235**
	:	**JURY TRIAL DEMANDED**
v.	:	
COUNTY OF LEHIGH and DALE MEISEL	:	

NOTICE

YOU HAVE BEEN SUED IN COURT. IF YOU WISH TO DEFEND AGAINST THE CLAIMS SET FORTH IN THE FOLLOWING PAGES, YOU MUST TAKE ACTION WITHIN TWENTY (20) DAYS AFTER THIS PLEADING IS SERVED BY ENTERING A WRITTEN APPEARANCE PERSONALLY OR BY ATTORNEY, AND FILING IN WRITING WITH THE COURT YOUR DEFENSES AND OBJECTIONS TO THE CLAIMS SET FORTH AGAINST YOU. YOU ARE WARNED THAT IF YOU FAIL TO DO SO, THE CASE MAY PROCEED WITHOUT YOU AND A JUDGMENT MAY BE ENTERED AGAINST YOU BY THE COURT WITHOUT FURTHER NOTICE FOR ANY MONEY CLAIMED IN THE COMPLAINT OR FOR OTHER CLAIMS OR RELIEF REQUESTED BY THE PLAINTIFF. YOU MAY LOSE MONEY OR PROPERTY OR OTHER RIGHTS IMPORTANT TO YOU.

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IF YOU CANNOT AFFORD TO HIRE A LAWYER, THIS OFFICE MAY BE ABLE TO PROVIDE YOU WITH INFORMATION ABOUT AGENCIES THAT MAY OFFER LEGAL SERVICES TO ELIGIBLE PERSONS AT A REDUCED FEE OR NO FEE.

LEHIGH REFERRAL SERVICE
LEHIGH COUNTY BAR ASSOCIATION
Old Courthouse, Room 304
Fifth and Hamilton Streets
Allentown, Pennsylvania 18105
Telephone: (610) 433-7094

2003 DEC 10 AM 9:58
PROTHONOTARY
CIVIL
LEHIGH COUNTY, PA

HAHALIS & KOUNOUPIS, P.C.

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IN THE COURT OF COMMON PLEAS OF LEHIGH COUNTY, PENNSYLVANIA

RUTH AROCHO, As Administratrix of the ESTATE OF ENRIQUE RENE VERAS and WADAYS VERAS and RUTH AROCHO as Parent and Guardian of CRYSTAL VERAS and YASHERA VERAS	:	**No.: 2003-C-3235**
	:	**JURY TRIAL DEMANDED**
v.	:	
COUNTY OF LEHIGH and DALE MEISEL	:	

COMPLAINT IN CIVIL ACTION

I. PARTIES

1. Plaintiff Ruth Arocho is an adult female citizen and resident of the Commonwealth of Pennsylvania, and is the duly appointed administrator of the Estate of Enrique Rene Veras, Deceased, and Parent and Natural Guardian of Minor Plaintiffs Crystal Veras and Yashera Veras.
2. Plaintiff Wadays Veras is an adult male citizen and resident of the Commonwealth of Pennsylvania.
3. At all times material hereto, Plaintiffs Wadays Veras, Crystal Veras and Yashera Veras were the children of Ruth Arocho and Enrique Rene Veras, Deceased, and heirs at law of Enrique Rene Veras, Deceased.
4. Defendant, County of Lehigh, maintains its principal office at Lehigh County Government Center, Allentown, Pennsylvania, and maintains operates and administers the Lehigh County Prison, in Allentown, Pennsylvania, and at all times has been a "public entity" under 42 U..S.C. § 12131.

5. Defendant, Dale Meisel (hereinafter "Meisel"), is an adult male citizen and resident of the Commonwealth of Pennsylvania. Meisel is currently serving in his capacity as Warden of the Lehigh County Prison and is responsible for the formulation and/or implementation of practices, policies, and procedures, as well as the day to day operation and overseeing and command and control of certain segments of the Lehigh County Prison, and who at all times relevant hereto was acting within the scope of his duties and authority, under color or title of state or municipal public law or ordinance and supervised or controlled one or more of the other Defendants herein in their conduct or actions, or acted in concert with them in the performance of their conduct or actions.
6. At all times relevant hereto, Defendant County acted by and/or failed to act by and through the conduct of its officers, managers, agents and employees, including but not limited to Meisel, all acting within the scope and course of their employment.
7. At all relevant times herein, Defendants County and Meisel knew, or had reason to know, of the actions and inaction alleged herein and/or has personally participated in some of said actions complained of herein, and are ultimately responsible for same.

II. FACTS

8. On or about December 5, 2002, Plaintiff's Deceased was incarcerated at the Lehigh County Prison.

9. Because of a significant history of mental illness, Plaintiff's Decedent was placed on "suicide watch."

10. Upon information and belief, the policies and practices of Lehigh County as pertain to the Lehigh County Prison provide that prisoners on suicide watch are maintained under constant video surveillance.

11. While Plaintiff's Decedent was on video surveillance by employees, agents and representatives of Defendant County of Lehigh, he fashioned a noose from his bedding, and hanged himself in his cell.

12. Upon information and belief, the policies and practices of the County of Lehigh were the direct and proximate cause of the constitutional harm caused to Plaintiff.

13. As the direct and foreseeable result of the policies and practices of Defendant County, Plaintiff's have been deprived of the support, society and companionship of Plaintiff's Decedent.

14. As the direct and foreseeable result of the policies and practices of Defendant County, Enrique Veras has been deprived of life, liberty and property, all in violation of his rights under the United States Constitution, particularly as guaranteed by the First, Fourth, Fifth and Eighth Amendments thereto.

III. CAUSES OF ACTION

COUNT I
PLAINTIFFS
v.
COUNTY OF LEHIGH AND DALE MEISEL
VIOLATIONS OF 42 U.S.C. § 1983

15. Paragraphs 1 through 14 inclusive, are incorporated by reference as if fully set forth at length herein.

16. The Defendants acted in concert with each other, and all Defendants acted under color of law, and violated the rights of the Plaintiff's Decedent by depriving him of his constitutionally protected right to free speech and to be free from malicious prosecution, false arrest, retaliatory prosecution, and other rights as guaranteed by the First, Fourth, Fifth and Fourteenth Amendments to the United States Constitution, in that Plaintiff's Decedent was subjected to terms and conditions of incarceration in violation of his rights under the First, Fourth, Fifth, Eighth and Fourteenth Amendments.

17. The actions of all the Defendants, collectively and individually in planning, conducting, and carrying out the incarceration of the Plaintiff's Decedent's person and the subsequent actions deprived the Plaintiff of his constitutional rights as guaranteed by the First, Fourth, Fifth, Eighth and Fourteenth Amendments to the Constitution, Section 8 of the Pennsylvania Constitution, and 42 U.S.C. Section 1983 in, *inter alia*, the following manners:

    a. In the unreasonable use of police power and authority, detention and prosecution;

b. In the intentional or negligent infliction of emotional distress upon the Plaintiff's Decedent, designed or calculated to punish the Plaintiff's Decedent;

c. In the development, implementation, and carrying out of a policy, practice or procedure which fails to adequately supervise and secure the person of Plaintiff's Decedent and deprivation of constitutional rights of citizens, such as the Plaintiff's Decedent;

d. In failing to develop, implement and carry out policies prescribing proper conduct of Corrections Officers when surveilling inmates to provide protection to the protected inmates of the Defendant County to be safe and secure in their persons and property;

e. In developing, implementing, and carrying out a policy, practice, or procedure or custom which made no reasonable or proper provision for application of law to provide protection to the inmates of the Defendant County to be safe and secure in their persons and property;

f. In failing to properly train, supervise, monitor and control the actions of all the Defendants so that proper procedures could be accomplished safely;

g. In failing to properly develop, implement and carry out a policy, practice, or procedure or custom which conformed with the Constitutional requirements in arrest, imprisonment, and prosecution of persons such as the Plaintiff's Decedent; and

18. As a direct and proximate result of the a foresaid actions and omissions of all Defendants, the Plaintiff has suffered the following injuries and losses and is entitled to the following damages:

a. loss of the use, benefit and enjoyment of life and personal freedom of movement and association;

b. physical and mental pain and suffering and anguish;

c. loss of valuable and inalienable rights to be free from illegal imprisonment, free from loss of freedom of association;

d. loss of income and future earning capacity;

e. loss of reputation;

f. punitive damages which are justified by the outlandish and outrageous conduct, actions, and omissions of one or more of the Defendants as aforesaid;

g. attorney's fees and costs to defend against the criminal action; and

COUNT II
PLAINTIFFS
v.
COUNTY OF LEHIGH AND DALE MEISEL
WRONGFUL DEATH – 42 Pa.C.S.A. § 8301

19. Paragraphs 1 through 18 inclusive, are incorporated by reference as if fully set forth at length herein.

20. As a direct and proximate result of the negligent and/or intentional actions of Defendants, Plaintiff has suffered the following damages and losses:

a. guidance, tutelage, and moral upbringing;

b. funeral and medical expenses;

c. the total earnings that would have been earned by the Plaintiff's Decedent during his life;

d. the economic value of the Plaintiff's Decedent's life;

e. special expenses provided for in 42 Pa. Cons. Stat. Ann. §

8301(c);

f. Such other damages as are cognizable in law.

COUNT III
ESTATE OF ENRIQUE VERAS
v.
COUNTY OF LEHIGH AND DALE MEISEL
SURVIVAL – 42 Pa.C.S.A. § 8302

21. Paragraphs 1 through 20 inclusive, are incorporated by reference as if fully set forth at length herein.

22. As a direct and proximate result of the negligent and/or intentional actions of Defendants, Plaintiff's Decedent suffered pain, suffering, loss of income, companionship, loss of life's pleasures, and such other damages as are cognizable at law.

V. PRAYER FOR RELIEF

23. Plaintiffs incorporates by reference paragraphs 1 through 22 of their Complaint as though fully set forth at length herein.

WHEREFORE, Plaintiff respectfully requests the Court to:

a. Exercise jurisdiction over their claims;

b. Issue declaratory and injunctive relief declaring the above-described practices to be unlawful, and enjoining their past and continued effects;

c. Award them compensatory damages, including but not limited to reimbursement of all medical and psychological expenses; back pay

and future earnings and loss of earning capacity in the amount of wages and benefits, damages for their mental, psychological and emotional injuries, anguish, humiliation, anxiety, physical and mental pain and suffering and loss of life's pleasures, all of which may be permanent, together with interest, resulting from Defendants' unlawful and tortious conduct;

d. Award them attorneys' fees and costs; and

e. Grant such other relief as the Court deems just and equitable.

JURY DEMAND

Plaintiff demands trial by jury.

Dated: December 8, 2004

HAHALIS & KOUNOUPIS, P.C.

By: _____

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Attorneys for Plaintiffs

IN THE SUPREME COURT FOR THE COMMONWEALTH OF PENNSYLVANIA

No. _____

RUTH AROCHO, As Administratrix of the ESTATE OF ENRIQUE RENE VERAS, WADAYS VERAS, and RUTH AROCHO As Parent and Natural Guardian of Crystal Veras and Yashera Veras
Petitioners

-vs-

COUNTY OF LEHIGH and DALE MEISEL,
Respondents

PETITION FOR ALLOWANCE OF APPEAL

Petition for Allowance of Appeal from the Order of the Commonwealth Court No. 1008 CD 2006 dated May 3, 2007 Affirming the Order of the Court of Common Pleas of Lehigh County No. 2003-C-3235 dated April 26, 2006 Granting Defendants' Motion for Summary Judgment

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STATEMENT OF THE BASIS FOR THE JURISDICTION

The Pennsylvania Supreme Court has jurisdiction over this Petition for Allowance of Appeal from a final order of the Commonwealth Court pursuant to 42 Pa.C.S. § 724. The Commonwealth Court had jurisdiction over an appeal from the final order of the Court of Common Pleas of Lehigh County, Pennsylvania granting Summary Judgment in favor of Lehigh County and Warden Dale Meisel pursuant to 42 Pa.C.S.A. § 762.

REFERENCE TO REPORT OF OPINIONS BELOW

On April 26, 2006, the Court of Common Pleas, Lehigh County granted Defendants' Motion for Summary Judgment. A copy of the Opinion and Order is attached as Exhibit A. On May 3, 2007, the Commonwealth Court of Pennsylvania affirmed the Court of Common Pleas. A copy of the May 3, 2007 Order and the Opinion of the Commonwealth Court is attached hereto as Exhibit B.

ORDER IN QUESTION

AND NOW, this 3rd day of May, 2007, the Order of the Court of Common Pleas of Lehigh County in the above-captioned matter, entered April 26, 2006, is hereby AFFIRMED.

/s/Mary Hannah Leavitt, Judge

See Appendix B for the Commonwealth Court's Order and Opinion.

QUESTIONS PRESENTED

1. Whether the Commonwealth Court erred in applying the decisions of the United States Supreme Court in *Farmer v. Brennan* and *Collins v. City of Harker Heights* in holding that Lehigh County Could Not be Held Liable for a Constitutionally Infirm Prison Suicide Prevention Policy?

2. Whether the Commonwealth Court erred in holding that Petitioners could not establish an unconstitutional condition of confinement for an inmate at risk of suicide where Plaintiff has proffered an unrebutted expert report that the conditions are constitutionally deficient?

STATEMENT OF THE CASE

The facts surrounding the death of Enrique Veras were stated by the Court of Common Pleas of Lehigh County as follows: [1]

A. MR. VERAS' HISTORY OF SUICIDE ATTEMPTS AT LEHIGH COUNTY PRISON

In February of 2002 Enrique Veras was incarcerated and immediately placed on "suicide precaution" status. On February 11, 2002, Mr. Veras tied a makeshift rope around his neck and tied it to the bars in a suicide attempt. Mr. Veras was returned to "suicide precaution" status on March 30, 2002 and remained on this status until he was released from Lehigh County Prison on April 2, 2002.

Enrique Veras returned to Lehigh County Prison on October 27, 2002, at which time he was placed on "suicide precaution" status. At the time of his arrest on October 27, Enrique Veras threatened to kill himself by placing a knife at his neck. He was seen at Sacred Heart Hospital, resulting in the following recommendation: "BE ABSOLUTELY WATCHFUL

[1] Except as noted with citation, the recitation of the facts are those found by the Court of Common Pleas.

OF HIS BEHAVIOR. CONSIDER THIS PATIENT HIGH RISK FOR REPEATED SELF-INJURY. MUST HAVE SOMEONE WATCHING HIM AT ALL TIMES."[2]

During the intake process at Lehigh County Prison, he expressed depression and threatened suicide. He gave a history of mental illness, psychiatric hospitalization and psychotropic medication. He was placed on suicide precautions in the reception unit (1D2) with the requirement of observation at fifteen minute intervals.[3] While there and under observation, Mr. Veras began throwing himself on the floor and wall of his cell causing head trauma. His was placed in the restraint chair and remained on fifteen minute observation for suicide precautions.[4]

The next day, again while on suicide precautions, Mr. Veras fashioned a noose from bedding, and was found hanging from the cell bars.[5] The nurse that responded opined "he's gone," but in fact Mr. Veras remained conscious and was placed in the restraint chair. After two and a half hours, he

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[2] R.R. v. 1 at p. 75a.
[3] R.R. v. 1 at p. 76a.
[4] *Id.*
[5] R.R. v. 1 at p. 79a

was released from the restraint chair and remained on suicide precautions of fifteen minute observation.[6]

On November 4, 2002, Enrique Veras was transferred to the Mental Health Unit and remained on "suicide precaution" status. Enrique Veras was removed from "suicide precaution" status on November 14, 2002.[7]

Subsequently, on December 4, 2002, Enrique Veras began to engage in self-injurious behavior. Consequently, Enrique Veras was placed in a "suicide precaution cell", specifically Cell 3223 that is located in the Administrative Segregation/Disciplinary Segregation Unit. A Corrections officer in a booth in the pod is responsible for monitoring the inmate on suicide precautions. If the correctional officer in the booth cannot observe the inmate from the control booth, one of the other Corrections Officers on the pod is required to go to the cell in order to check on the inmate.

The policies of the Lehigh County Prison require that a cell to be used as a "suicide precaution cell" must be subject

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[6] *Id.*

[7] Although not found as a fact by the Court, this removal coincided with Mr. Veras being placed in Disciplinary Segregation for destruction of property in connection with his October 28 suicide attempt. R.R. v.1 at p. 80a.

to the best sight line available from the control booth, and be an "open bar" cell. The cells used by Lehigh County Prison as "suicide precaution cells" are supposed to have direct access to the officers and in the visual field of the officers most of the time to make sure that there is nothing that the prisoners can hang themselves with or hang onto.

Immediately upon being placed in the cell in 3C1, Mr. Veras began banging his head on the floor, bunk and wall; throwing himself from the top bunk onto the floor, attempted to flush his head down the toilet, and trying to hang himself by tying his underwear around his neck and to the towel bar in the cell. He was again placed in the restraint chair.[8]

As a result, Enrique Veras was given a blanket and was stripped naked, and upon authorization from the medical department, was placed in a restraint chair between 8:45 P.M. and 9:00 P.M.. Between 10:30 P.M. and 10:45 P.M., correctional officers attempted to remove Enrique Veras from the restraint chair, but Enrique Veras refused to leave the restraint chair, stating that he would harm himself if he were

[8] *Id.*

removed. The medical department placed Enrique Veras on "suicide precaution" status at 11:18 P.M. Enrique Veras was removed from the restraint chair at 12:30 A.M. on December 5, 2002.

On December 5, 2002 at approximately 4:10 P.M. Enrique Veras was found in Cell 3223 standing with his back to the cell door with a ligature around his neck and tied to the cell door. The ligature was characterized as bed linen or a sheet. The correctional officers immediately cut the ligature and summoned medical attention. Enrique Veras was transferred to the hospital where he was pronounced dead at 4:54 P.M.

B. Lehigh County Prison's Suicide Prevention Policy

1. Policy Relating to Monitoring Seriously Suicidal Inmates

Lehigh County Prison has a suicide prevention policy (No. 5.5, effective April 5, 2001) which states that the facility will "provide special housing, increased levels of observation, and medical restraint to those inmates who display self-destructive

behavior."[9] The policy references being based upon standards for suicide prevention policies separately promulgated by the American Correctional Associate (ACA) and the National Commission on Correctional Health Care (NCCHC). The County has never contended that these standards are not applicable to them.

The ACA standards require a provision that mandates constant observation for suicidal inmates.[10] The NCCHC standards require that an inmate assessed as a high suicide risk be observed on a "continuing, uninterrupted basis or be transferred to an appropriate health facility."[11] Corrections Director Edward Sweeney has testified that the Lehigh County Prison suicide prevention policy was based upon those standards.[12]

According to the references section of the LCP policy, a National Corrections Institute Publication was also consulted. That publication,[13] is a report prepared by Lindsay Hayes,

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[9] R.R. v. 1 at p. 59a.
[10] R.R. v. 1 at p. 51a
[11] R.R. v. 1 at p. 57a - 58a; 73a.
[12] R.R. v. 1 at p. 104a.
[13] Excerpted at R.R. at pp. 47a - 58a.

Plaintiff's expert in this case. Director Sweeney reviewed Lindsay Hayes' publications in the process of issuing the LCP Suicide Prevention policy.[14] The recommendations in that report echo the NCCHC requirements for continuous observation of actively suicidal inmates on a one-on-one basis, either by a member of the corrections staff or a fellow inmate.

The LCP policy does not require constant observation of inmates at high risk of suicide, nor does the policy on its face even provide for the possibility of constant observation. Director Sweeney, who issued the policy, had no explanation for why there was no specific provision for constant observation. He stated that there was no reason to omit this classification.[15]

The Corrections Officer in the booth, has a view of the cell in which Mr. Veras was housed (3C1), which is partially obstructed by a staircase.[16]

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[14] R.R. v. 1 at p. 102a.
[15] R.R. v. 1 at p. 105a.
[16] A photograph of the view from the Desk in the Control Booth from which Mr. Veras was supposed to be observed is contained in the record and is reproduced in Appellant's Brief to the Commonwealth Court at p. 10.

2. Policy Relating to Housing Seriously Suicidal Inmates

The NCCHC standard requires that a cell designated for suicide prevention "be as nearly suicide-proof as possible (i.e. without protrusions of any kind that would enable the inmate to hang him/herself."[17] However, the cells used as "suicide prevention" cells at LCP are not suicide resistant in that there are multiple ligature anchor points accessible to the inmate.[18]

The Lehigh County Prison policy provides for only two levels of observation for suicidal inmates: suicide precautions and close observation.[19] The policy does not delineate any real difference between the monitoring of inmates in the two levels, and the deposition testimony of all of the witnesses reveals that the only difference is whether the inmate is maintained clothed or stripped naked.

The suicide prevention cells at LCP all have open face bars, towel bars, and clothing hooks, all of which are potential

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[17] R.R. v. 1 at p. 18a - 21a; 73a.
[18] R.R. v. 1 at p. 116a – 117a.
[19] R.R. v. 1 at p. 60a. The policy also provides for medical restraint (ie. the "restraint chair") as a temporary measure. R.R. at p. 61a.

and easily recognizable ligature anchor points.[20] Director Sweeney has understood that the cells with open faced bars, including the one in which Mr. Veras committed suicide, are not safe for suicidal inmates in that the open bar cells provide multiple ligature points.[21] Director Sweeney stated that an open bar cell is not suicide resistant, since "obviously . . . someone could certainly tie something to the door."[22] Director Sweeney also understood that that there are no suicide resistant cells at the Lehigh County Prison.[23]

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[20] In fact, the Lehigh County Prison policy requires that open bar cells be used for suicide prevention. R.R. v. 1 at p. 125a. The Warden designates what cells are used for suicide prevention. R.R. v. 1 at p. 125a. However, Director Sweeney was the Warden at the time that the suicide cells were designated, and current Warden, Dale Meisel, did not change the designations when he became Warden.

[21] R.R. v. 1 at p. 116a – 117a.

[22] *Id.*

[23] R.R. v. 1 at p. 119a – 120a.

PETITION FOR ALLOWANCE OF APPEAL

The United States Supreme Court has held that a prison official may be liable under 42 U.S.C. § 1983 if he knew that the inmate faced a substantial risk of serious harm and disregarded that risk by failing to take reasonable measures to abate it. *Farmer v. Brennan*, 511 U.S. 825, 847 (1994). In this case, the record is clear that Enrique Veras faced a substantial risk of serious harm from suicide. Lehigh County conceded not only that Mr. Veras had a peculiar risk of suicide, but that the prison officials knew that he did.

Under *Farmer*, the only remaining question was whether Lehigh County Prison failed to take reasonable measures to abate the risk to Mr. Veras. However, rather than follow the clear directions of the United States Supreme Court, both the Court of Common Pleas and the Commonwealth Court embarked upon a parallel enquiry as to whether the general record of suicides and suicide attempts at the Lehigh County Prison put the prison officials on notice of the need for different suicide precautions.

This enquiry was improper because *Farmer* set up two distinct methods of proof as to whether there was a substantial risk of harm from suicide: one enquiry when the prison officials did not have actual notice of a peculiar risk to a particular inmate; and a separate enquiry where the prison officials had recognized that a particular inmate was at risk of suicide. The tests are mutually exclusive. In this case, Lehigh County Prison officials had recognized that Enrique Veras was at imminent risk of suicide, and had placed him on suicide precautions. At the time of his death by suicide, he had been on suicide precautions for approximately eighteen hours. There was no need to further enquire into whether there was a general risk at the prison.

The Commonwealth Court further erred in opining that whether the second part of the *Farmer* test, whether the prison officials took reasonable precautions to abate the known risk of suicide to the inmate, was a question for the Court. The Commonwealth Court cites to *Farmer* for this startling and unprecedented rule, but fails to designate from whence it was drawing this rule. In fact, no such statement is made in

Farmer, and the delegation of the question of whether reasonable steps were taken to the Court is contrary to precedent of the Commonwealth of Pennsylvania and the Federal Courts.

The record supported the conclusion that Lehigh County Prison knew that the provisions that it made for housing suicidal inmates was not proper, and therefore that the precautions were not reasonable. The lower courts erred in deciding the question of reasonableness as a matter of law, and also erred in completely disregarding the uncontested opinion of Plaintiff's expert, Lindsay Hayes, that the LCP procedures were constitutionally infirm.

REASONS SUPPORTING ALLOWANCE OF THE APPEAL

I. The Commonwealth Court Did Not Follow the Controlling Decisions of the United States Supreme Court in *Farmer v. Brennan* and *Collins v. City of Harker Heights*

A. The Commonwealth Court Failed to Properly Apply *Farmer v. Brennan*

The United States Supreme Court has imposed § 1983 liability in a prison suicide case where the prison officials are "deliberately indifferent" to the inmates peculiar vulnerability to suicide. "Deliberate indifference" is a term of art the meaning of which has developed over time. The controlling decision by the United States Supreme Court defines the standard as "a prison official may be held liable under the Eighth Amendment for denying humane conditions of confinement only if he knows that inmates face a substantial risk of serious harm and disregards that risk by failing to take reasonable measures to abate it." *Farmer v. Brennan*, 511 U.S. 825, 847 (1994).

The Court in *Farmer* parsed the first requirement into two subparts,

> (1) the detainee had a particular vulnerability to suicide; and
>
> (2) the custodial officer or officers knew of that vulnerability

511 U.S. at 836 ("the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference"). The *Farmer* opinion equates the last factor with a breach of duty. 511 U.S. at 845 ("Whether one puts it in terms of duty or deliberate indifference, prison officials who act reasonably cannot be found liable under the Cruel and Unusual Punishments Clause.")

The Supreme Court explained that the term "deliberate indifference" lies "somewhere between the poles of negligence at one end and purpose or knowledge at the other." *Farmer*, 511 U.S. at 836. It is by this standard – and only this standard – that the Lower Courts were required to consider this case. As demonstrated below, the Lower Courts erred by confusing standards set forth in pre-*Farmer* cases and those applicable in other kinds of § 1983 cases.

1. Knowledge of Vulnerability

In this case, LCP and Warden Meisel conceded for the purposes of their Motion for Summary Judgment that these factors are supported by the record. Even if they had not so conceded, it is undisputed that Enrique Veras had been diagnosed as an immediate suicide risk, and was on Suicide Precautions at the time of his death. Therefore, the standard is met that Enrique Veras had a particular vulnerability to suicide (by virtue of the undisputed diagnosis) and the custodial officers knew of that vulnerability (they maintained him on suicide precautions).

The Lower Courts both placed great emphasis on the lack of a significant history of prior suicides at the Lehigh County Prison. Under *Farmer*, the record of prior suicides and suicide attempts may be relevant to the subjective knowledge enquiry, but only if there was no evidence of subjective knowledge of a particular vulnerability to suicide of the inmate in question.

> Whether a prison official had the requisite knowledge of a substantial risk is a question of fact
>
> * * *
>
> and a factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious
>
> * * *
>
> [I]f an Eighth Amendment plaintiff presents evidence showing that a substantial risk of inmate attacks was "longstanding, pervasive, well-documented, or expressly noted by prison officials in the past, and the circumstances suggest that the defendant-official being sued had been exposed to information concerning the risk and thus 'must have known' about it, then such evidence could be sufficient to permit a trier of fact to find that the defendant-official had actual knowledge of the risk

Farmer, 511 U.S. at 842-43. Since there is no question that the prison and its top officials had actual knowledge of Mr. Veras' particular vulnerability, the prior record (or lack thereof) of suicide attempts is not a proper consideration.

2. Reasonable Measures to Abate the Risk

There is both an objective and a subjective component to a deliberate indifference claim – Did the prison official have

subjective knowledge of a peculiar or general risk; and were the measure taken to abate the risk objectively reasonable. *Farmer*, 511 U.S. at 846 ("to survive summary judgment, he must come forward with evidence from which it can be inferred that the defendant-officials were at the time suit was filed, and are at the time of summary judgment, knowingly and unreasonably disregarding an objectively intolerable risk of harm"); *See also Montgomery v. Pinchak*, 294 F.3rd 492, 499 (3rd Cir. 2002). The only question at issue on Summary Judgment in this case was the second question: whether the Lehigh County Prison failed to take objectively reasonable steps to abate the danger to Enrique Veras. *Farmer*, 511 U.S. at 847 ("a prison official may be held liable under the Eighth Amendment for denying humane conditions of confinement only if he knows that inmates face a substantial risk of serious harm and disregards that risk by failing to take reasonable measures to abate it.")

The Commonwealth Court also erred in requiring proof of *scienter*. Appendix B, p. 8; 2007 Pa. Commw. LEXIS 197, *27. In so holding, the Commonwealth Court mistakenly relied

upon the opinion of the Third Circuit in *Simmons v. City of Philadelphia*, 947 F.2d at 1060-1061. n13. However, the Supreme Court repudiated such a requirement in *Farmer*. The standard of purposeful or knowing conduct is not necessary to satisfy the requirement of deliberate indifference. *Id.* at 836. The Supreme Court further clarified that it did not intend to require a plaintiff to show an intent to harm on the part of the prison, nor did it require direct evidence of the prison's knowledge of the vulnerability. 511 U.S. at 842. Nor must an Eighth Amendment claimant show that a prison official acted or failed to act believing that harm actually would befall an inmate; it is enough that the official acted or failed to act despite his knowledge of a substantial risk of serious harm. *Id.* at 842.

B. The Commonwealth Court has Consistently Misapplied *Collins v. City of Harker Heights* As to the Liability of a Municipality for Constitutional Torts Committed by Municipal Actors Who Themselves Have No § 1983 Liability

The Commonwealth Court has linked municipal liability under Section 1983 to proof that a municipal actor is liable for a constitutional tort. In this case, the Commonwealth Court engaged in an extensive analysis of the liability of Warden Meisel, 2007 Pa. Commw. LEXIS 197, *20-32, ultimately holding that Warden Meisel was not liable under § 1983. The Court then disposed of the *Monell* claim against Lehigh County, holding that

> This Court has expressly adopted the *Trigalet* analysis. *Thomas v. City of Philadelphia, 804 A.2d 97, 112 (Pa. Cmwlth. 2002)* ("We hold, therefore, that in the absence of an underlying unconstitutional action by employees of the City . . ., we will not consider the question of whether the City [has liability] . . ."); *Robbins v. Cumberland County Children and Youth Services, 802 A.2d 1239, 1250-1251 (Pa. Cmwlth. 2002)* (accepting the "reasoning of the vast majority of federal circuits, which adopt the general rule that a municipality

> cannot be liable unless there is a constitutional violation by the municipal actor causing the plaintiff's harm").

2007 Pa. Commw. LEXIS 197, *34.

The Court recited the *"Trigalet"* analysis as

> a municipality cannot be held liable in a *Section 1983* action in the absence of a predicate unconstitutional act by the municipality's employee. Even if the municipality's actions are arbitrary or even "conscience shocking, in a constitutional sense" the municipality cannot be held liable under *Section 1983. Id.* [*Trigalet v. City of Tulsa, Oklahoma,* 239 F.3d 1150 (10th Cir. 2001)] *at 1151.* This is because a claim of "inadequate training [or] supervision . . . under *§ 1983* cannot be made out against a supervisory authority absent a finding of a constitutional violation by the person supervised." *Id. at 1154* (quoting *Webber v. Mefford, 43 F.3d 1340, 1344-45 (10th Cir. 1994)).*

2007 Pa. Commw. LEXIS 197, *33-34. This is an accurate statement of the law, as the Third Circuit recognized in *Brown v. Pa. Dep't of Health Emergency Med. Servs. Training Inst.,* 318 F.3rd 473, 482-483 (3rd Cir. 2003). However, a municipality may be held independently liable for a substantive due process violation even in situations where

none of its employees are liable, but have nonetheless violated plaintiff's constitutional rights, *Collins v. City of Harker Heights*, 503 U.S. 115, 122, 117 L. Ed. 2d 261, 112 S. Ct. 1061 (1992) (emphasizing "the separate character of the inquiry into the question of municipal responsibility and the question whether a constitutional violation occurred."). However, "It is not enough that a municipality adopted with deliberate indifference a policy of inadequately training its officers. There must be a "direct causal link" between the policy and a constitutional violation," *Canton v. Harris*, 489 U.S. 378, 385 (1989).

This distinction between municipal liability where no municipal actor has liability under § 1983, and where no municipal actor has violated constitutional rights, is a crucial one, and one which the Commonwealth Court clearly does not understand. A governmental entity is liable under Section 1983 where action pursuant to a municipal policy or custom causes a constitutional tort. *Monell v. Department of Social Services of the City of New York*, 436 U.S. 658, 691 (1978). "[I]t is when execution of a government's policy or custom . . .

inflicts the injury that the government as an entity is responsible under § 1983." *Id.* at 694.

Fourth Amendment claims such as excessive force or arrest without probable cause by police, as in *Canton* and *Monell*, by necessity require action by a municipal employee – a police officer – to bring about the constitutional harm. An Eighth Amendment claim, on the other hand, arises out of taking no action in reliance upon a policy which dictates that no action be taken. The municipal actor (ie. the corrections officers) who are directly involved with the inmate would have no liability for their inaction, because they are acting in accordance with a facially (from the their perspective) valid policy.

The Commonwealth Court mistakenly found that Petitioners based their appeal on *Fagan v. City of Vineland*, 1993 U.S. App. LEXIS 20327 (3rd Cir. 1993), *aff'd* 22 F.3rd 1296 (3rd Cir. 1994)(*en banc*). Recognizing that the *Fagan* decision was roundly criticized, not for its actual holding, but for the implication of that holding, the Commonwealth Court refused to follow *Fagan* in *Robbins*, which held that "a

municipality cannot be liable unless there is a constitutional violation by the municipal actor causing plaintiff's harm." 802 A.2d at 1251. The implication that the Commonwealth Court was rejecting was that there could be municipal liability even if the actions of the municipal actors did not violate the Constitution. Even the Third Circuit has repudiated this in *Brown*.

In *Robbins*, the Commonwealth Court held that a child protective services agency had no duty under § 1983 to protect a child that was not in its custody from private violence, and as there was no breach of any constitutional duty, it was irrelevant whether any municipal policy was improper. The Court never considered whether the County policies were infirm, because the Plaintiff simply failed in its proof that there was any duty owed by the municipal actor.

In *Brown*, the Plaintiff alleged that the City of Philadelphia had a number of policies involving EMTs which were enacted with deliberate indifference and which caused harm to them and their son. Like the Commonwealth Court in *Robbins*, The Third Circuit held that they failed to establish

that the City's policies caused constitutional harm because the City was under no constitutional obligation to provide competent rescue services to Plaintiff from privately-caused harm.

However, there is a clear and established obligation to protect an inmate from a known risk of suicide. Youngberg v. Romeo, 457 U.S. 307 (1982); Estelle v. Gamble, 429 U.S. 97, 103, (1976); Commonwealth, Dep't of Public Welfare, Farview State Hosp. v. Kallinger, 134 Pa. Cmwlth. 415, 423 (Pa. Cmwlth. 1990). The Courts' disagreement with *Fagan* is therefore not pertinent to this case, and proper enquiry can be made into the constitutional adequacy of the Lehigh County Prison Suicide Policy.

As set forth above, the duty in this case has been established, since Mr. Veras had a particular vulnerability to suicide which was recognized by the prison by putting him on suicide precautions. Defendants did not contest, and in fact admitted, and the Court accordingly found that the suicide prevention policy was an official policy enacted by Warden Meisel and ratified by Director Sweeney. The question

remains as to whether those precautions were a reasonable effort to abate the vulnerability to suicide. If not, then the Corrections Officers' actions in compliance with and in furtherance of those policies would be in violation of the Constitution, even if none of them would be liable under the "shocks the conscience" standard. That is the question that remains to be decided by a jury.

II. The Commonwealth Court Erred in Permitting the Question of "Reasonableness" of the Prison Suicide Prevention Policies to be Decided by the Court Rather than By a Factfinder

a. Whether Conduct is Reasonable is a Jury Question

The Commonwealth Court held that the question of whether the Prison's response to the known threat of suicide was a question for the Court, referring without citation to *Farmer*. Appendix B, p. 9; 2007 Pa. Commw. LEXIS 197, *31. ("It is for the courts to determine, under *Farmer*, whether particular conduct is so unreasonable as to constitute the infliction of cruel and unusual punishment.") The Commonwealth Court does not state where in *Farmer* it has

found this pronouncement, and in fact, the Supreme Court has not so delegated this question.

The reasonableness of a particular course of action is the quintessential jury question. *See Boyle v. Pennsylvania R. Co.*, 403 Pa. 614, 616 (Pa. 1961); *Mackowick v. Westinghouse Electric Corporation*, 373 Pa. Super. 434, 541 A.2d 749, 750-51 (Pa. Super. 1988); *Hadar v. Avco Corp.*, 2005 PA Super 326, *12 (Pa. Super. 2005). Appellants identified two major issues relating to whether the County took "reasonable measures to abate the risk." First, the LCP policy does not require, or on its face even provide for, constant uninterrupted observation of inmate on suicide precautions, as set forth in the NCCHC standards, and what observation required is conducted from a place that has inadequate sightlines to permit a proper level of observation from the Control Booth. Second, the suicide cell on 3C1 is dangerous for suicidal inmates in that it provides multiple ligature anchor points on which an inmate may hang himself.

The Lower Courts misinterpreted the decision of the United States Supreme Court in *Bell v. Wolfish*, 441 U.S. 520

(1979) in which the Court held that published standards for prison conditions, while not determinative of constitutional requirements, may be instructive as the accepted standards for prison conditions. 441 U.S. at 543 n. 27. While NCCHC and ACA standards are not binding standards, they are certainly evidence of what are reasonable steps to abate the risk of suicide. *Gates v. Cook*, 376 F.3rd 323 (5th Cir. 2004)(ACA accreditation and compliance with standards are relevant considerations but not dispositive of compliance with the Eighth Amendment (citing *Bell*).

In fact, the LCP suicide prevention policy is based upon both sets of standards, but follows neither. The prison was not able to explain its decision not to follow the standards. This raises a clear question of whether the decision – the product of deliberation – was reasonable. An unreasonable decision which is the product of deliberation is "deliberate indifference." Pembaur v. City of Cincinnati, 475 U.S. 469, 483-84 (1986)("municipal liability under § 1983 attaches where a deliberate choice to follow a course of action is made from among various alternatives by the official or officials

responsible for establishing final policy with respect to the subject matter in question.") The Lower Courts impermissibly intruded into the fact finding function of the jury in determining that the decision to depart from accepted industry standards was reasonable.

b. The Court May Not Make a Decision on Reasonableness As a Matter of Law in the Face of Expert Evidence that the Conduct Was Not Reasonable

Expert testimony is often employed to help jurors understand issues and evidence which is outside of the average juror's normal realm of experience. We have stated that, the employment of testimony of an expert rises from necessity, a necessity born of the fact that the subject matter of the inquiry is one involving special skill and training beyond the ken of the ordinary layman. *Reardon v. Meehan*, 424 Pa. 460, 465, 227 A.2d 667, 670 (1967). Conversely, if all the primary facts can be accurately described to a jury and if the jury is as capable of comprehending and understanding such facts and drawing correct conclusions from them as are

witnesses possessed of special training, experience or observation, then there is no need for the testimony of an expert. *Young v. DOT*, 560 Pa. 373, 376-77, 744 A.2d 1276, 1278 (2000). Although there do not appear to be any reported cases on the question of whether expert testimony is mandatory in a § 1983 case, standards for the incarceration of seriously suicidal inmates are not within the common ken of a layperson, and expert testimony is therefore required.

Normally a plaintiff may establish his case with any evidence, direct or circumstantial. Where, however, the ultimate determinations lie beyond the knowledge or expertise of the average layperson, expert testimony is permitted (and sometimes required) to aid the jury in its understanding of the factors involved and the teaching of the pertinent discipline with respect thereto. *Reardon v. Meehan*, 424 Pa. 460, 227 A.2d 667 (1967); *Weisman v. Sauder Chevrolet Co.*, 402 Pa. 272, 167 A.2d 308 (1961); *Densler v. Metropolitan Edison Co.*, 235 Pa.Super. 585, 345 A.2d 758 (1975); *Hamil v. Bashline*, 481 Pa. 256, 266-267, 392 A.2d 1280 (Pa. 1978)

The question of whether competent and unchallenged expert evidence on a material issue itself precludes Summary Judgment was addressed by this Court in the context of medical negligence in *Hamil.* In that case, the Court noted that

> Whereas typically a plaintiff alleges that a defendant's act or omission set in motion a force which resulted in harm, the theory of the present case is that the defendant's act or omission failed in a duty to protect against harm from another source. To resolve such a claim a fact-finder must consider not only what *did* occur, but also what *might* have occurred, *i.e.*, whether the harm would have resulted from the independent source even if defendant had performed his service in a non-negligent manner

481 Pa. at 270, 392 A.2d at 1287. The Court therefore held that where there is at issue the adequacy of services rendered therefore, a *prima facie* case of liability is established by expert testimony. The Court therefore reversed the award in favor of Defendants.

Similarly, in *Hightower-Warren v. Silk,* 548 Pa. 459; 698 A.2d 52 (1997), this Court held without reliance on *Hamil*, that judgment was improperly entered against Plaintiff, and she

was entitled to a jury trial because the proffered testimony of her expert, when all inferences were drawn her favor, established a *prima facie* case.

One recent reported case suggests that where a Plaintiff has produced relevant and admissible expert evidence, it is error to grant Summary Judgment. In *Morningstar v. Hallett*, 2004 PA Super 337, P16 (Pa. Super. Ct. 2004), the Superior Court reversed the Court of Common Pleas of Franklin County's entry of summary judgment on the issue of whether the grant of summary judgment was in error in denying her the opportunity to present expert evidence and testimony. In that case, the Court of Common Pleas had ruled that the expert evidence in question would not be admitted. The Superior Court overruled both the exclusion and the grant of Summary judgment, holding that there was no support in the record for the exclusion of the proffered testimony, and that since the testimony is directly relevant to the claim Summary Judgment was inappropriate.

There is no principled distinction between a medical negligence case, in which the theory is that the defendant's

omission failed in a duty to protect against harm from another source, and a section 1983 conditions of confinement case, in which the theory is the same. In this case, there has been no consideration of Plaintiff's expert evidence at all. Both the Court of Common Pleas and the Commonwealth Court have simply ignored this evidence. Indeed, Lehigh County has never suggested that Mr. Hayes testimony would not be admissible.

CONCLUSION

The Court of Common Pleas once recognized that this is not a case which is clear and free from doubt as to whether the Lehigh County Prison and Warden Meisel acted reasonably in response to a known risk of serious injury. This was the correct decision. Thereafter, this case took a tortuous route, made even more convoluted by the errors discussed herein. This Petition for Allowance of Appeal requests that this Honorable Court correct the errors of law perpetuated by the Commonwealth Court in the interest of all future inmates who are threatened by suicidal ideation.

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(3)

No. 07-1361

FILED
MAY 29 2008
OFFICE OF THE CLERK
SUPREME COURT, U.S.

In The
Supreme Court of the United States

RUTH AROCHO, As Administratrix of the ESTATE OF ENRIQUE VERAS, WADAYS VERAS, and RUTH AROCHO as Parent and Natural Guardian of C.V. and Y.V.,

Petitioners,

vs.

COUNTY OF LEHIGH and DALE MEISEL,

Respondents.

On Petition For Writ Of Certiorari To The Commonwealth Court Of Pennsylvania

BRIEF OPPOSING PETITION FOR WRIT OF CERTIORARI AND APPENDIX

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REASONS FOR DENYING CERTIORARI

The decision to grant the Motion For Summary Judgment of Respondents, Lehigh County and Warden Dale Meisel, made first by the Lehigh County Court of Common Pleas and affirmed by a full, *en banc,* seven-judge panel of the Commonwealth Court of Pennsylvania, was correctly decided using the standard of "deliberate indifference" enunciated in *Farmer v. Brennan*, 511 U.S. 825 (1994), analyzing all of the pleadings and evidence of the circumstances specific to the former inmate, Enrique Veras. *Arocho v. County of Lehigh et al.*, No. 2003-C-3235 (Court of Common Pleas of Lehigh County, April 26, 2006); *affirmed*, 922 A.2d 1010 (Pa. Cmwlth. 2007). Thereafter, the Supreme Court of Pennsylvania correctly rejected Petitioners' invitation to grant allowance of appeal. *Arocho v. County of Lehigh et al.*, 944 A.2d 759 (Pa. 2008).

The instant Petition is meritless and presents no question worthy of the grant of certiorari. Petitioners urge this Court to clarify the standard of "deliberate indifference" enunciated in *Farmer*, *supra*, but Petitioners do so by ignoring the reality that no lack of clarity has been perceived in the standard or in its consistent application by the Circuit Courts of Appeal, notwithstanding that Circuit Courts have addressed a variety of circumstances involving prisoners who attempted or inflicted self-harm. See, e.g., *Brown v. Harris*, 240 F.3d 383 (4th Cir. 2001); *Frake v. City of Chicago*, 210 F.3d 779 (7th Cir. 2000); *Liebe v. Norton*, 157 F.3d 574 (8th Cir. 1998); *Barrie v. Grand County Utah*, 119 F.3d 862 (10th Cir. 1997);

Manarite By and Through Manarite v. City of Springfield, 957 F.2d 953 (1st Cir. 1992); *Rhyne v. Henderson County*, 973 F.2d 386 (5th Cir. 1992).

In fact, it is only because Respondents are mindful of the obligation imposed by Sup. Ct. R. 15(2), to address any misstatement in the petition bearing on issues that might be before the Court, that Respondents submit this opposing brief. Petitioners make many misstatements of fact and law, use suggestion and insinuation as techniques to misrepresent evidence and mischaracterize lower court holdings and reasoning throughout their Petition.

To open, Petitioners ignore Sup. Ct. R. 24(1)(a) by including text in addition to the questions presented on the first page of their Petition. The additional text should perhaps be disregarded for this reason alone. Additionally, the noncompliant text is the first of Petitioners' misstatements, that the Pennsylvania courts "applied a blanket prohibition to the introduction of prevailing corrections standards." Petition at p. i. In fact, Pennsylvania's Commonwealth Court applied no such prohibition. A review of the Commonwealth Court's decision reveals that the court did not foreclose all future plaintiffs from presenting evidence of industry standards in cases involving inmates with suicidal tendencies, but rather determined that in the specific circumstances involving the former inmate Mr. Veras (which were viewed in the light most favorable to the Petitioners, as required under the summary judgment analysis), the proffered corrections standards, even in combination with Petitioners' expert

witness's opinion, were not enough, in and of themselves, to show that either the County or Warden Meisel acted with deliberate indifference to the former inmate Enrique Veras. Petitioners had no other evidence to offer, testimony or otherwise, that tended to show that Respondents acted with deliberate indifference in violation of the Eighth Amendment prohibition against cruel and unusual punishment.

All that Petitioners offer now, in lieu of evidence, is a collection of misstatements, mischaracterizations and insinuations to suggest that the County acted with deliberate indifference and that the Pennsylvania courts erred at all three levels. To identify just a few significant examples, Petitioners state that the former inmate was transferred to disciplinary segregation because of his suicide attempt, thereby insinuating that the County was inflicting punishment for the suicide attempt. Petition, at p. 5, ¶1. Nevertheless, the undisputed evidence shows this is not the case. At the County prison, the suicide resistant cell was located in the administrative (non-disciplinary) and disciplinary segregation housing unit ("AS/DS"), in which inmates are housed one to a cell with more corrections officers to watch them. Placement of the former inmate on the AS/DS segregation unit was in no way intended to punish him for his suicide attempt.

Other misstatements Petitioners offer for the same purpose are (1) that Ed Sweeney, Director of Corrections at Lehigh County, stated there was no penological justification for the absence of "constant observation" in the County's suicide prevention policy,

Petition, at p. 7, ¶1; (2) that Director Sweeney "admitted that the cells used as 'suicide prevention' cells at Lehigh County Prison are not suicide resistant" and he "was aware of this deficiency," Petition, at p. 7, ¶2; (3) that Director Sweeney "understood that the cells with open-faced bars are not safe for suicidal inmates in that the open bars provide multiple ligature points," Petition, at p. 8, ¶1; and (4) that the record supports the conclusion that Lehigh County knew its housing of suicidal inmates was improper. Petition at p. 11, No. 6. All of the foregoing statements are inaccurate representations of the evidence. For this reason, Respondents appended all pertinent portions of the actual depositions to this brief so this Court may see how misleading the Petitioners' brief is. *See* Appendix, pp. 4-49.

In the remainder of the Petition, Petitioners offer this Court their own misperception of the deliberate indifference standard enunciated in *Farmer*, *supra*, by suggesting that the standard requires a court to analyze all of the actions that might have been taken by prison officials to prevent an inmate with suicidal tendencies from taking his or her own life, to next consider all of the actions actually taken by the prison and its officials to promote the safety of the former suicidal inmate and to conclude by asking whether the actions taken were reasonably calculated to succeed in light of what else could have been done. This may be what Petitioners would like the standard of deliberate indifference to be, but it is not the standard adopted by this Court in *Farmer*, *supra*. To adopt Petitioners' interpretation of the standard

would be to replace the higher standard of deliberate indifference with the lower standard of negligence, after this Court has determined that negligent actions simply do not rise to the level of cruel and unusual punishment. *Farmer,* 511 U.S. at 840.

Petitioners' misperception of the standard is the main factor that causes their fault-finding with the lower court's decision to be lacking in merit. Petitioners compound this error by making multiple misstatements and mischaracterizations of the Commonwealth Court of Pennsylvania's holdings and reasoning.

For example, Petitioners accuse the lower court of refusing to consider the opinion of its expert witness, Lindsay Hayes, and misapplying principles articulated in *Bell v. Wolfish,* 441 U.S. 520 (1979). Petition at p. 19, ¶15. Petitioners also assert that the lower court misapplied, out of context, principles articulated in *Spruill v. Gillis*, 372 F.3d 218 (3d Cir. 2004). Petition at p. 15, ¶12. Finally, Petitioners cite to a recent decision of this Court addressing Equal Employment Opportunity Commission regulations, *Federal Express Corp. v. Holowecki*, ___ U.S. ___, 128 S.Ct. 1147 (2008), for a principle that is not articulated therein. Petition at p. 19, ¶15. The foregoing are identified because they are the more glaring examples of Petitioners' overreaching misstatements and mischaracterizations.

It is necessary only to read the well-reasoned opinion of the Commonwealth Court of Pennsylvania to see the extent of the Petitioners' misstatements, so

Respondents will not take up this able Court's time by parsing the Pennsylvania court's opinion here. To assist this Court in its reading of that opinion, Respondents have supplied the text from that opinion that was omitted from Petitioners' appendix, which erroneously printed page 31 twice after page 29 and omitted page 30. Petition, App. Vol. I, p. 29, 31. *See* Appendix, pp. 1-3.

CONCLUSION

The Petition presented here is an end-stage attempt on behalf of a disappointed client, and it is completely lacking in merit for all of the reasons set forth above. Respondents request this Court to deny the Petition for Writ of Certiorari and allow the decision of the Commonwealth Court of Pennsylvania to stand.

Respectfully submitted,

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IN THE COMMONWEALTH COURT
OF PENNSYLVANIA

Ruth Arocho, As Administratrix of the Estate of Enrique Rene Veras and Wadays Veras and Ruth Arocho as Parent and Guardian of Crystal Veras and Yashera Veras, Appellants	:	
v.	:	No. 1008 C.D. 2006
County of Lehigh and Dale Meisel	:	Argued: December 13, 2006

BEFORE:

HONORABLE JAMES GARDNER COLINS, President Judge
HONORABLE BERNARD L. McGINLEY, Judge
HONORABLE DAN PELLEGRINI, Judge
HONORABLE BONNIE BRIGANCE LEADBETTER, Judge
HONORABLE RENÉE COHN JUBELIRER, Judge
HONORABLE ROBERT SIMPSON, Judge
HONORABLE MARY HANNAH LEAVITT, Judge

OPINION
BY JUDGE LEAVITT FILED: May 3, 2007

The children and estate (Estate) of Enrique Veras (Decedent),[1] who committed suicide while incarcerated at the Lehigh County Prison (Prison) on December 5, 2002, appeal a judgment of the Court of Common Pleas of Lehigh County (trial court). By this judgment, the trial court held that the Estate could not sustain its 42 U.S.C. §1983 action for damages against Dale Meisel, the Prison Warden, or against Lehigh County for their alleged violations of Decedent's constitutional rights. In this case we consider whether the trial court erred by

* * *

This Court has expressly adopted the *Trigalet* analysis. *Thomas v. City of Philadelphia,* 804 A.2d 97, 112 (Pa. Cmwlth. 2002) ("We hold, therefore, that in the absence of an underlying unconstitutional action by employees of the City . . . , we will not consider the question of whether the City [has liability] . . . ".); *Robbins v. Cumberland County Children and Youth Services,* 802 A.2d 1239, 1250-1251 (Pa. Cmwlth. 2002) (accepting the "reasoning of the vast majority of federal circuits, which adopt the general rule that a municipality cannot be liable unless there is a constitutional violation by the municipal actor causing the plaintiff's harm"). The Estate counters that this Court should follow *Fagan v. City of Vineland,* 22 F.3d

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[1] Appellant Ruth Arocho is the administratrix of Decedent's estate and the mother of Decedent's minor children, Crystal Veras and Yashera Veras. Appellant Wadays Veras is Decedent's adult child.

1283 (3d Cir. 1994). As this Court has explained, *Fagan* has not even been followed by the Third Circuit in subsequent cases, and the *Fagan* analysis was expressly rejected by this Court in both *Thomas and Robbins. Thomas,* 804 A.2d at 111.[17]

Because the Estate failed to make the threshold showing that a municipal employee, Meisel, violated the Decedent's constitutional rights, the Estate's claim against Lehigh County fails.

Nanty-Glo

The Estate raises an additional challenge on appeal: that the trial court impermissibly relied upon oral deposition testimony in violation of the rule announced by our Supreme Court in *Borough of Nanty-Glo v. American Surety Co.*

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[17] The Estate argues that the Third Circuit has returned to the *Fagan* approach, citing to *Brown v. Commonwealth of Pennsylvania, Department of Health Emergency Medical Services Training Institute,* 318 F.3d 473 (3d Cir. 2003). The Estate fails to understand, apparently, that this Court decided in *Thomas* and in *Robbins* to join the view of the majority of federal appellate courts in holding that a "municipality cannot be liable unless there is a constitutional violation by [a] municipal actor." *Robbins,* 802 A.2d at 1251.

IN THE COURT OF COMMON
PLEAS OF LEHIGH COUNTY
CIVIL DIVISION – LAW

RUTH AROCHO, As Administratrix of the ESTATE OF ENRIQUE RENE VERAS and WADAYS VERAS and RUTH AROCHO as Parent and Guardian of CRYSTAL VERAS and YASHERA VERAS,	:	NO. 2003-C-3235
Plaintiffs	:	
vs.	:	Jury Trial Demanded
COUNTY OF LEHIGH and DALE MEISEL,	:	
Defendants	:	

DEPOSITION OF EDWARD SWEENEY

Taken at the offices of Lehigh County Prison, 38 North Fourth Street, Allentown, Pennsylvania, on Thursday, September 8, 2005, commencing at 11:10 a.m., before Daniel R. Stout, Certified Court Reporter, Notary Public.

APPEARANCES:

HAHALIS & KOUNOUPIS
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* * *

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* * *

[5] Q. Can you give me your educational background?

A. Graduate of William Allen High School and a graduate of DeSales University, then St. Francis de Sales, with a degree in Business Management, Bachelor's of Science.

Q. It was DeSales University Allentown College at the time you were there?

A. St. Francis de Sales.

Q. Oh, I'm sorry, a different one.

A. No, it's now de Sales University.

Q. Okay. What year did you graduate?

A. 1990 I believe.

Q. What year did you graduate from William Allen High School?

[6] A. '79.

Q. Okay. In between high school – .

When did you enter St. Francis de Sales?

A. I'm going to say around 1988.

Q. My math would indicate you completed college in two years?

A. I had an Associate's Degree from Lehigh County Community College.

Q. I see. And when did you get that?

A. I believe I completed that in 1982.

Q. Okay. When you were at L-tri-C were you there full-time?

A. No. Well, I guess it would have been full-time. It was twelve – . Yes, it would be considered full-time.

Q. Okay. Did you maintain some full-time employment while you were at L-tri-C?

A. Yes.

Q. What was that?

A. I worked as a store clerk at a Turkey Hill Mini-market on Lehigh Street.

Q. That was a full-time job?

A. Yes.

Q. Okay. After you –

[7] A. I was the Assistant Manager.

Q. You say that with a bit of glee in your eye.

A. It was enjoyable.

Q. Okay. When you got your degree from L-tri-C did you seek some other employment?

A. I worked at Lehigh Valley Dairy for a brief time before starting to work for Lehigh County Department of Corrections in 1984.

Q. I forgot to ask what was your Associate's Degree in?

A. I think it was Business, as well.

Q. What was your first position with Lehigh County Department of Corrections?

A. Corrections Officer.

Q. How long were you a Corrections Officer for?

A. Two years.

Q. In 1984 what did the – what training were you given to assume the job of Corrections Officer?

A. Relatively little. There was an assignment made to a mentor or quote, unquote, Training Officer, who I shadowed for about two weeks, was supposed to shadow for two weeks, but it [8] was reduced to one week because I was doing so well, and that was the extent of the training.

Q. Do you remember who you were shadowing?

A. Wayne Kratzer and Charles Payne.

Q. Did you – . Well, after the Camp Hill program was started, did you go to the Camp Hill Academy as well?

A. No, I did not. The Department had started bringing in some trainers during my tenure as a CO and I had some basic Corrections Officer security training programs that we facilitated in-house with the State Department of Corrections employees providing the training.

Q. Was that between '84 and '86?

A. Yes.

* * *

[15] Q. How long were you the Warden at the interim – at the Salisbury facility?

A. Until March of 1993.

Q. By the way, Salisbury, was Salisbury remember a secure facility?

A. Yes.

Q. Other than your prior experience and educational background, what other qualifications did you need to possess to be the Warden at Salisbury?

A. Correctional experience as well as those job – I mean those educational requirements which I mentioned.

Q. And what happened in March of '93?

A. I became – I was transferred to the Warden's position here at the main prison.

Q. Does that mean you became a Warden 2?

A. Actually the – . I was reclassified – . The position of Warden 1 was reclassified to a position of Warden 2 in the year prior, so I was already at the same pay grade as I was in March of '93. It was an administrative decision made by the then Director of Corrections to switch his two Warden 2's to have Warden Meisel transferred to the Salisbury and myself transferred to here.

[16] Q. Okay. Who was the Director of Corrections at that time?

A. Richard Klotz.

Q. Who I believe was your immediate predecessor, as well, is that right?

A. As the Director, yes.

Q. Okay. And how long were you the Warden here? You actually were the Warden here, correct?

A. Yes. From March of 1993 until I believe it was July of 1999, when I was appointed as the Director of Corrections. I maintained the responsibility of the Warden until February of 2002. I wore two hats for that time frame between '99 and '02.

Q. Is Director of Corrections an appointed or hired position?

A. It is appointed.

Q. By whom?

A. The County Executive, with confirmation by the Board of Commissioners.

Q. Did you have any competition for the position that you know of?

A. Not that I know of.

Q. Who was the County Executive at that time?

* * *

[17] Q. Other than the formal education you've discussed before and any on-the-job training that you've gotten through the prison, have you pursued any unstructured education in the field of corrections, Penology, or anything of that nature?

A. Yes.

Q. Can you tell me about that?

A. At least twice a year for the last fifteen years I have gone to a variety of trainings, most of which were provided by the Pennsylvania Prison Wardens Association or another association, the Pennsylvania County Prison Wardens Association, County Commissioners Association of Pennsylvania, some AJA trainings, some – American Jail Association is AJA – American Corrections Association training, training

by the National Institute of Corrections in Colorado on at least two occasions, also in Virginia with the National Institute of Corrections.

Q. Are those all the agencies that you've trained with in the last fifteen years?

A. There may have been some privately run trainings which I went to as well, but I don't recall the names of those facilitators or companies.

* * *

[20] Q. Thank you. Are there journals relating to Corrections and Penology?

A. Yes.

Q. Do you subscribe to any?

A. Correctional Law Reporter, American Jail Association.

Q. Anything else?

A. I have a lot of them sent to me. Whether I actually subscribe to them or not, I don't really know. I don't think I do. I think the only ones that we actually fill out subscription and send in every year are the two which I just mentioned.

Q. Are there others which you regularly receive that you actually –

* * *

[45] Q. Okay. Would you agree with me that there's no separate level of observation in your policy called constant observation?

A. Yes.

Q. Okay. Why not?

A. It can be ordered by the doctor.

* * *

[48] The medical practitioner makes a determination of a level of supervision, correct?

A. Yes.

Q. The policy determines what the conditions of that supervision will be, correct?

[49] A. Well, –

Q. Bad question. Let me ask it a different way.

The Medical determines the level of supervision, the policy dictates the circumstances of their custody?

A. With exceptions.

Q. Well, what are the exceptions?

A. You brought up something earlier about constant supervision.

Q. Okay.

A. There have been numerous cases where doctors have ordered constant supervision.

Q. Okay.

A. And in those cases there's been a staff person actually assigned, who sits there and continually monitors this person while they're on precautions.

* * *

[54] Q. You've never reviewed any material, seen any discussion, of solid plastic doored cells?

A. No.

Q. You've never heard of the idea of placing Plexiglas over the inside of barred cells to prevent inmates from using the bars as a hanging point?

A. No.

Q. Can you think of any reasons why those methods would not – those two ideas would not be proper suicide prevention techniques?

A. You wouldn't be able to see through it after about six months.

Q. Why do you say that?

A. Because it would be scratched, stained, smeared.

Q. Okay. Do you have any idea what the cost of a piece of one-inch Plexiglas the size of a cell door would be?

A. No, no idea.

Q. When you say scratched, what would an [55] inmate on suicide precautions scratch a door with that's made of Plexiglas or Lexan?

A. Fingernails.

Q. Did you ever try to do that?

A. No.

Q. Do you think – do you know that that's possible, to scratch Plexiglas with your fingernails?

A. No, I don't have any firsthand experience with trying to scratch. I can only say that I've seen plastic that we've done at different locations for types of small windows and things for pass-throughs which have hands around them in many cases, and they are very quickly scratched and become opaque.

Q. Okay. And that's inmates who might be wearing clothing, might have belts, might have anything in their hands, might have jewelry, correct?

A. Absolutely.

Q. And all of those things would be normally deprived – or always deprived of a person on suicide precautions, correct?

A. If you had a cell that was completely dedicated to a certain level of suicide precaution, [56] yes.

Q. Okay. When you said that the Plexiglas would become stained, how would it become stained?

A. Food, feces.

Q. Do you have any actual knowledge that Plexiglas or Lexan is porous enough to actually stain regardless of what the substance was?

A. No firsthand knowledge.

Q. Did you consult – have you ever consulted with anyone as to how to properly outfit a suicide prevention cell?

A. No.

Q. And when I say you in that scenario, I don't mean you personally necessarily, but under your direction has anybody ever inquired of any outside entity or person as to what the characteristics of a suicide prevention cell should look like or should be?

A. Not expressly. I mean I get trade magazines on an ongoing basis, I go to trade shows on an ongoing basis which show all different types of suicide related restraints and garb and things of that nature, and beds and different types of equipment, but there's never been anything that has been provided or that I have seen that is similar to [57] what you are referring.

Q. Okay. Assuming for the sake of this question, which I know is going to be a big assumption, but assuming for the sake of this question that Lexan or Plexiglas cannot be stained by feces or food and cannot be scratched with one's fingernails, can you think of any Correctional purpose to not having a solid door clear cell to use as a suicide cell?

A. Security.

Q. Okay. How would that affect security?

A. Well, it would have to have – to be of a strength in which it would withstand someone trying to come through the door.

* * *

[58] Q. Do you know how it was determined what cells should be barred and what cells should be solid?

A. No.

Q. Okay. Other than in A tower, being involved with the decision of what cells would – .

Well, when you were dealing with A [59] tower, how did you decide which ones would be barred and which ones would be solid doored?

A. Well, as I'm thinking about all of this, I believe that was actually a discussion about the fact that we didn't have any doors in A tower on 1-A. There was a whole discussion about if we should do a housing unit with no doors, and we talked about, you know, barred grill doors and opaque solid doors, and ultimately we went with no doors, and that may well have been more of what the discussion was, rather than – .

Because I don't recall any conversation – . Because 4-A is a gym, 3-A is a general population housing unit with all solid doors, 2-A is the same. There's no special housing. They're not in direct or special housing units. So they all have solid doors. So the

only discussion I would have had was on 1-A, and we went with no doors.

Q. Okay.

A. You can't get any more open and clear than that.

Q. Okay. You can't get any more clear than that.

* * *

[60] Are all of the suicide prevention cells such as they are open bar cells?

A. I believe so, yes.

Q. Okay. So my question isn't having open bar cells. I'm assuming that they're open bar cells. How was it determined which open bar cells would be ones used for inmates on suicide precautions?

A. I don't believe that there was a definitive decision being made and presented at some point along the way back before 2002 in which we [61] delineated, at least from my level, which I delineated which cells would be used for monitoring of suicide precautions, so it may well have just been one of those circumstances which evolved.

* * *

[65] Q. Are there any cells in this facility that staff is regularly within close enough proximity that they – that the inmates would be visible to them?

A. No more so than on 3-C.

Q. Now, as I understand it 3-C is a – during the day is a three Officer unit?

A. Yes.

Q. One in the booth, two roaming around?

A. Right.

Q. I don't mean to stay that in a sarcastic way, but two roving.

A. Yes.

Q. I also understand that there might be other personnel that might be roving around, there might be a Lieutenant roving around and a Sergeant might also be roving around, is that correct?

A. That's correct, and maybe a Utility, also. There's a Utility assigned to each floor and typically by practice on the third floor on many occasions the third floor Utility Officer ends up on 3-C.

* * *

[79] Now, do you – are you familiar with the concept of suicide-proofing a cell?

A. It's kind of self-evident in the statement.

Q. Well, I'm wondering does that have any special penological meaning to suicide-proof a cell?

A. Well, normally you would, if you were going to have a person in what would be a suicide precaution or a therapeutic seclusion or clinical seclusion, you would have as much out of the cell as possible,

including protrusions and things like that on the walls.

Q. Okay. Are you aware of any standards or other recommendations that indicate that a suicide-proofed cell should also have no hooks, no towel bars, and nothing that could be used as an anchor point?

A. I know that I've read that. Whether it's actually in a –

Q. Standard?

A. – standard, I'm not sure.

Q. Okay. Would you consider this cell suicide-proof, 3223?

A. The door obviously is not suicide-proof in that someone could certainly tie something to the [80] door.

The bed in and of itself is not suicide-proof in that somebody could tie something around the base of the beds itself right along the anchors.

The furniture in there is designed otherwise as being suicide-proof in that the shelf is rounded and that if there are hooks, they're breakaway suicide-precaution hooks for hanging of towels.

Q. Okay. Now, the hooks, when you say they're breakaway, in fact what they do is they collapse downward in case anyone exerts any kind of weight on it?

A. Right.

Q. As farfetched as it seems, you could actually impale yourself on those hooks, could you not?

A. They're rounded, flat, rounded metal.

Q. Meaning what? They do come to a point at the end, correct?

A. No, they're rounded. They don't come to a point.

Q. Okay. So your testimony is you could not impale yourself on the bars?

[81] A. Correct.

* * *

Q. Okay. Is there any reason you know of why a non-suicide-proof cell is being used as a suicide precaution cell?

A. We do not have any padded room, if that's what – . I mean, you know, we use cells in multiple different locations where we have inmates who might be in need of suicide precaution, but we don't have cells in all those areas that are completely stripped, as we use them for regular housing, as well.

* * *

[94] Q. Who makes psych decisions, psychological, including psychiatric decisions, for inmates? For treatment I should say?

A. The medical staff.

Q. Is it always that way?

A. Yes.

Q. And is there a reason why it's that way?

A. Standards would dictate that it's that way.

Q. Standards?

A. National Commission of Corrections Health Care Standards.

Q. Okay. Now, with your policies, like your [95] suicide policy, what's the relationship between that policy and what the medical staff can do and can order? Does that policy govern your medical staff?

A. No.

Q. Does that policy work as a guide for the medical staff?

A. Yes.

Q. What do you mean by a guide but not govern it?

A. If the doctor, as I said before, wanted to put somebody on a constant watch, he could order that, he would just write that on that form where it says other, he could write continuous, if they would feel that someone is legitimately suicidal and they want to move forward with either a 303 or a 304 type of proceeding. They initiate that.

Q. Is it correct to say then that the medical staff drives decision-making and decision-making regarding psychological issues for inmates, psychological treatment for inmates?

A. Yes.

Q. What is your role, what is your role as of December 2002 in the prison – when I say December 2002 I mean you've shed your Warden's hat, you're just the Director – in general what's your [96] role in the prison? What was your role in the prison?

A. At that point I was no longer actively involved in any of the day-to-day operations. In other words I did not review shift packs that dealt with everything that happened from the day before, I was not the person immediately contacted whenever there was a question or a concern regarding the day-to-day operations.

A lot of the issues as far as decision-making when it comes to inmate grievances or misconduct proceedings and parole recommendations, all of those type of things are at the Warden level, which I no longer dealt with any of that.

My role became more administrative oversight, trying to steer more and shape the Criminal Justice system as it interplays with the prison in order to control population and do some different things from a policy perspective.

* * *

[103] Q. Has medical staff, whether they were contract or whether they worked for you, in your knowledge ever informed you that putting an inmate, a suicidal risk inmate in a open bar cell is dangerous for that inmate?

A. No. In fact, it's just the opposite. That's where they want them.

Q. We had talked about sealed doors and open doors. The solid doors, is there a pass-through on the solid doors?

A. Some, not all.

Q. Some of them are completely sealed, some of them have pass-throughs?

A. Some of them have a pass-through.

* * *

[104] Q. Could a cell be made suicide-proof in a practical sense?

A. Well, you could certainly make a cell as suicide-proof as possible. I mean I don't think that there's any cell that is suicide-proof. I mean even if you – unless it is a cell, a bare cell with absolutely nothing in it, and I mean no cot, no anything. Any type of bunk gives an opportunity to be able to tie something to it, because even the suicide bunks that they use for restraints have places on them in order to attach the restraints. If there's any – if there's

anyplace on a bunk to be able to secure a ligature, you can certainly still commit suicide.

* * *

IN THE COURT OF COMMON PLEAS
LEHIGH COUNTY, PENNSYLVANIA

RUTH AROCHO, As Administratrix of the ESTATE OF ENRIQUE RENE VERAS and WADAYS VERAS and RUTH AROCHO as Parent and Guardian of CRYSTAL VERAS and YASHERA VERAS	:	
vs.	:	
COUNTY OF LEHIGH AND DALE MEISEL	:	NO. 2003-C-3235

DEPOSITION OF DALE MEISEL

Taken at the Lehigh County Prison, located at 38 N. 4th Street, Allentown, Pennsylvania, commencing approximately at 12:40 p.m. on **August 29, 2005**, before Maureen L. Stewart, a Registered Professional Reporter and Notary Public of the Commonwealth of Pennsylvania.

* * *

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* * *

[7] background and I'll try not to interrupt you, and then I'll ask you some questions about that and then

I'll ask you to give me your work background. So can you give me your educational background?

A I have a bachelor's degree in political science from Duquesne University in Pittsburgh. I have a master's in the administration of justice from Wichita State University in Wichita, Kansas. And I have a master's in business administration from Marymount University in Arlington, Virginia. I also have a paralegal certificate from Penn State.

Q In what year did you get your BA?

A '68.

Q And your administration of justice, is that an MA or an MS?

A It's an MAJ.

Q Oh, it's its own thing?

A Yes.

Q In what year did you get your MAJ?

A '76.

Q And your MBA?

A '86 or '87.

Q And your paralegal certificate?

A I got that about two or three years ago.

Q Off the record before we started, it was [8] mentioned that you were in the Army.

A Correct.

Q What years did you serve in the Army?

A From 1968 to 1988.

Q How much of that was active duty?

A All of it.

Q What was the highest rank you attained?

A Major.

Q What year were you promoted to major?

A I think that was like '78, '79.

Q In your military career did you have some specialty or some particular thing you were assigned to?

A Well, my basic branch was Military Police Corps, but I also served in the armor calvary special forces as an infantry officer and also served in the artillery as a logistics officer.

Q Could you give me which order they were?

* * *

[22] Q When you retired in 1988, what did you do?

[23] A Went job hunting.

Q Did you have any particular career in mind?

A Well, I wanted to be a school teacher, but – because I had done some self analysis and realized

that I really enjoyed teaching. Unfortunately, Pennsylvania is not friendly to people who want to be teachers, but don't have teaching degrees. So that was pretty much not a real valid career choice for me.

Q By the way, did you retire for any reason other than you had your 20 in?

A No.

Q So ultimately what did you end up deciding to do?

A Well, the stronger aspect that I knew was my security background, my military police background, and so I started to network for jobs in that field and ultimately I ended up answering a want ad for this, for Lehigh County.

Q When did you start with the Lehigh County Prison System?

A It was in February of 1989.

Q What position did you start with?

A Deputy warden.

[24] Q How long did you remain deputy warden?

A Not long.

Q Where did you go from there?

A Warden.

Q How long have you been warden?

A Well, I have been warden twice.

When did you become warden the first time? And a ballpark is okay in this juncture.

A I think it was within, like, I want to say six months, nine months.

Q Sometime in late 1989?

A Yes. It could have been earlier.

Q How did it come to be that you became warden?

A Because what happened was the director left – the first director of corrections that Lehigh County had, and then the warden moved up to director.

Q Who was that?

A That was Glenn Jeffes. And Glenn Jeffes had been the Commissioner of Corrections for the State of Pennsylvania, so he was eminently qualified. So I didn't want to work for anybody else, so I applied for the job.

Q How long did you remain warden the first time?

* * *

[26] A He gave it to me.

Q Let's go back to February of 1989 when you were deputy warden the first time.

A Yes.

Q I'm sorry, was there a difference between deputy warden in 1989 and assistant warden in 1994?

A Yes.

Q Okay. We'll come back to that sequentially, but thank you for giving me some guidance there.

Had your prior background fully prepared you to be deputy warden?

A No.

Q In what way?

A Mainly, in the complexities and the idiosyncrasies of Pennsylvania law. Corrections is corrections, you know, the general principles that [27] you apply in one prison or jail, you can generally apply elsewhere in terms of how you supervise inmates, how you supervise staff, what happens in the normal course of events inside an institution. But specific Pennsylvania law issues and how the law affects the operation, that was something that I had to learn.

Q Anything else?

A Not really.

Q What did you do to bring yourself up on the Pennsylvania idiosyncrasies?

A Studied, read the law read Title 37, asked questions, picked the brain of Glenn Jeffes, who was –

Q Eminently qualified to have his brain picked?

A – a rich resource of corrections experience, 30 years. He was a real dynamo, so someone that definitely one could learn from.

Q Did you have to do anything else when you became warden the first time? Was there anything else you had to do to assume whatever duties additional were thrust upon you as warden?

A Are you asking me if there were some qualifications or some training or something that I [28] had to undergo?

Q That works.

A No.

Q Did you feel yourself fully prepared to be warden the first time?

A No.

Q Is there anything that you chose to do to increase your, for lack of a better word, skillset to be warden?

A Again, it was a question of reading, researching, asking questions, that sort of thing.

Q Aside from experience, aside from the degrees you have already told me about, have you had any other formal education touching upon corrections?

A No. I mean, I took the paralegal courses specifically so that I could better understand the law as it applied to corrections.

Q And you said you went to Penn State?

A Yes.

Q Or you got it from Penn State?

A Yes.

Q Was that an actual in residence program or –

A No, it was night school.

* * *

[31] Q That are considered to be authoritative, in other words, if you walked into any warden's office, you are likely to see a particular set of books?

A Not like the law books in a law library. I think it is up to the interests of a particular warden. I mean, you can walk into my office and see rather an eclectic selection of books. The Internet and the National Institute of Corrections, NIC, does regularly publish various studies and documents of all kinds.

Q Are there any newsletters that might not be considered periodicals that you regularly read?

A No. I get Security Management, which is the publication of IASIS, International American Society of Industrial Security.

Q Do you ever read any newsletter called Jail Suicide Mental Health Update?

A I have seen that, yes.

Q Is that something you subscribe to?

A No.

Q Do you normally access that by downloading it?

A I'm not sure that I have ever downloaded it. I have typically seen it in hard copy.

* * *

[34] Q Under the policies that stood in 1995, as assistant warden what information were you given on a regular basis concerning inmates who had been identified as suicide risks, if any?

A The only information that I received regularly was through the shift packet that was produced on a 24-hour basis.

Q Now, Captain McFadden has told us about shift packages that he got in the normal course of his duties as captain. Is that the same packet that you would have gotten as assistant warden?

A Exactly the same.

Q Has the composition of that packet changed in the last ten years?

[35] A Sure. It has evolved. Some things are added, things are taken out.

Q Is there anything you would have gotten as assistant warden in 1995 that Captain McFadden would not have gotten as a shift package in 2002?

A No, not in terms of the basic incident reports, that hasn't changed.

* * *

[45] Q Let me ask it a different way. Other than a policy promulgated by the Lehigh County Department of Corrections, are there any other entities that have promulgated policies by which you are bound?

A By which I am bound, no.

Q By which the prison is bound.

A No.

Q So any policies that you have to follow – that the prison must follow are those promulgated by the Lehigh County Department of Corrections?

A Yes.

Q Anything that is promulgated by the Pennsylvania Department of Corrections, it has no binding effect on you as a county prison?

A Only if it is in Title 37.

[46] Q Of the code or of the statutes?

MR. LOUX: The Code.

THE WITNESS: If you say so.

BY MR. DERATZIAN:

Q We're talking about as opposed to something enacted by the legislature or something that is created by the Pennsylvania Department of Corrections in the Administrative Code.

A Yes.

Q The regulations.

A Yes.

Q I assume that you at some point in familiarizing yourself with Pennsylvania law and keeping yourself up to date you actually read the Pennsylvania regulations as applying to county prisons?

A Yes.

Q Would you agree with me that they more or less dictate the sorts of policies you are required to have, but don't really tell you what those policies have to be?

A Title 37 back then at any rate was very nondefinitive for the most part.

Q In other words, as I have read it, it suggests that you should have a policy on mental [47] health, you should have a policy on health in general and things like that, but it doesn't tell you what the guidelines should be?

A There might be some details that they specify, but very few.

Q Would you agree with me that Title 37 doesn't specify what your suicide prevention policy has to be?

A I would agree with that, yes.

Q Just you have to have one?

* * *

[56] Q How would it come about or how was it supposed to come about that inmate monitors were put into place?

A Basically, from the medical staff. They would direct it.

Q How were inmate monitors selected?

A I don't know the exact process of selecting them. I can speculate.

Q Well, let's start out with, who was doing the selecting?

A I believe it came through the treatment department. The medical department had to work with the treatment department who would identify the potential inmate monitors.

Q What is the treatment department?

A The treatment department is the department that is made up of case management, classification, jobs, programming.

Q What is the medical department?

A The medical department is the department [57] that provides medical care – professional medical care for psychiatric, medical, et cetera for the inmates.

Q Is that entirely outsourced, the medical department?

A Now?

Q Well, let's just talk about 2002. As of 2002 was the medical department completely outsourced?

A Yes.

Q Was that to an entity known as Wexford?

A Wexford Health Sources, I believe, was their name.

* * *

[71] Q Can you explain to me how a cell is designated as a suicide cell in this system?

A It has to be an open bar grilled cell and it has to have sightlines – the best sightline available from the booth.

Q Who makes the decision of what cells will be suicide cells?

A I guess ultimately I sign off on it, but based on the recommendation of other people.

Q What other people or what other types of people, if you can't give me names?

A I believe it was a combination of custody and treatment staff.

Q Is open bar and good sightlines the only criteria for a cell being designated a suicide cell?

A I believe so.

Q Does Director Sweeney have any involvement in designating a suicide cell?

A I don't think so.

Q Now, the only cell I have seen is 3223 that's designated as a suicide cell. Is that still [72] designated as a suicide cell?

A As far as I know.

Q You have never undesignated it as a suicide cell?

A No.

Q As far as you know it was designated as a suicide cell in December of 2002?

A I don't know if it was formally designated back then or not. I don't know if any cells were formally designated.

Q As things stand today is there a written document that formally designates a cell as a suicide cell?

A Yes.

Q Do you recall there being written documents on or before December of 2002 that formally designated a cell a suicide cell?

A I don't believe that there were.

* * *

[73] Q I'm going to try to describe 3223 and I'm going to ask you a question. As I recall, 3223 has an open bar door. And if you go straight back, there is a bed – a cot and then off to the left is a desk [74] area and a toilet area. Does that sound about right?

A I believe so.

Q As I saw it, the desk and the toilet bowl area are recessed from the open area of the bars. Do you agree with that? In other words, let me ask it a different way. In other words, the bars are not as wide as the whole cell; correct?

A That's correct.

Q And there is a solid wall area behind which is the toilet and the desk?

A An angled wall.

Q Are there any cells that were used as suicide cells in 2002 that were not designed exactly like that?

A No.

Q Have you ever had occasion to be in the control booth on 3C?

A Sure.

Q Would you agree with me that if you are in the control booth you don't have a sightline to the toilet area in 3223?

A I would have to actually stand there and look. I mean, I have never really stood there and looked at 3223 specifically to see what I could see.

Q As of December of 2002 had you ever stood [75] and looked at the view provided for any suicide cell from any control booth?

A No.

Q If someone is on close observation, who is supposed to be doing the observing?

A The corrections officer.

Q Some of the corrections officers have described the situation as there generally being three corrections officers to a unit. Is that typically the case in this prison?

A No.

Q How is it typical in this prison?

A How is what typical?

Q How many officers to – other than at night, how many COs to a unit?

A To a general population unit, one. At that time, one.

Q What about to a – what are we calling AS/DS, special management or –

A Well, you'll find a number of different designations. Some people will call it RHU, Restricted Housing Unit, others will call it the BAU, Behavioral Adjustment Unit. That is really kind of an archaic name that we don't use. It is AS/DS.

Q Were there more officers assigned to [76] AS/DS?

A Yes.

Q Would that be three to a unit?

A That was – well, that's the only AS/DS unit. So three, yes.

Q Of the three who was supposed to be doing the close observation?

A Any one of the three. I don't believe that it is specifically designated.

Q Are you aware of any common practice that the close observation is performed only by the booth officer?

A No.

Q Is that the way it is supposed to be?

A No, I don't believe so.

Q Do you know of any reason why the officers should actively share the duty of close observation?

A Say that again.

Q Is there any reason why the officers should actively share the duties of close observation?

A They are equally responsible for the care, custody, and control of the inmates. So it would make sense that they would share those duties [77] as well.

Q Do you know of any reason why the duties should not be limited to the booth officer only?

A Do I know of any reason why the duty should not be limited?

Q Bad question. Do you know of any reason why the booth duties should not be performed only by the booth officer?

A Again, they are all responsible for the care, custody, and control of the inmates.

Q Am I correct that the booth officer barring some personal need is supposed to remain in the booth throughout his or her shift or barring an emergency?

A Sometimes what happens is the booth officer will go in and make a round and someone else actually then takes his position. So he is not restricted. If he wants to go in and do a round, he is certainly permitted to do that.

Q So if one person is scheduled to be the booth officer, he is not tied to the booth, he can walk around if he wants to?

A Well, his primary duty is the booth and the expectation is that he is going to be the person primarily pushing the buttons, but that doesn't mean [78] that he can't go in and walk around.

Q Am I correct that the shortest – let's move off of close observation and go to suicide precautions, which I understand to be the next higher level of observation, is that correct, under the Lehigh County Prison policy?

A Yes.

Q What does that mean?

A What does what mean?

Q What does suicide precautions mean?

A Suicide precautions involves a more elaborate procedure. The inmate's possessions are taken away from him. He may be or he is stripped of his clothing, extraneous materials are removed from the cell, and he is given a blanket – this is under now the 2001 policy – given a blanket, and then is put under a more frequent observation.

Q As I understand it, the most frequent observation the policy dictates is 15 minutes; is that right?

A Correct.

Q Now, if you know this, I'm going to make myself one of the doctors working in the health unit and I want to designate someone as needing more frequent observation, can I do that?

[79] A Yes.

Q How would I do that?

A Issue a medical order.

Q But I want the person to be observed more than the policy relates to, more than 15 minutes?

A Yes.

Q I'm allowed to do that?

A Yes.

Q How do I know that?

A I don't know the answer to your question.

Q If you know the answer to this, if I'm a doctor and I'm a brand new Primecare doctor, am I given some material by the prison that tells me the rules under which I operate?

A We have a number of policy books throughout the prison. One of them is located in the medical department and it contains the prison policies. That is there for the referral of the staff – for the use of the medical staff. They have their own set of policies also.

* * *

[80] Q Had you ever read anything or been present for any lectures or in any way come to any information that housing suicide risks on AS/DS units was a bad idea?

A No.

* * *

[82] Q Have you ever read any published guidelines for what a suicide cell should look like?

A I believe there is some guidelines in the NCCHC that talk about that.

Q Do they not suggest that the door be made of a resistant clear material?

* * *

[84] Q Well, wouldn't a cell with a solid clear door be isolated enough to prevent inmates from passing things into the cell?

A I don't think so.

Q Why not?

A Because I don't believe that is a good idea, number one – your suggestion. And, two, I don't necessarily believe that it is going to be totally sealed.

Q Why do you believe that is not a good [85] idea having a solid clear door?

A Because I believe that in very short order that clear material whatever it is made of would be scratched to the point where it would be opaque. Graffiti is a fact of life.

Q Well, presumably we have someone who has no possessions, correct, because they are on suicide

precautions; correct? So they shouldn't have anything that they can use to scratch with.

A Well, they have feces.

Q Well, would you agree – and I don't mean to nitpick – would you agree with me that that is not an abrasive substance?

A That is correct, but –

Q So why else would that be –

A Because the inmate –

Q – a bad idea?

A If there is someone who is not on suicide precautions, that person could be in that cell.

Q Is there any particular reason why there isn't at least one cell designated solely for someone on suicide precautions in this facility?

* * *

[111] Q As you testified there were three officers on AS/DS except for nighttime; is that correct?

A Yes.

Q And is it correct that there is one officer in the booth, two officers who walk the pod?

A Yes.

Q Is any one officer supposed – any one position, not an individual officer, but any one assigned

position supposed to be in charge of observing suicide precaution inmates?

A No.

Q Is it acceptable that it is the booth CO who checks on suicide precaution inmates?

[112] A As long as he can see them.

Q So is it appropriate if the suicide precaution inmate is in a cell – open barred cell where he can be seen that the CO in the booth is the one that does the routine checks on him? Is that appropriate?

A Yes.

* * *

[113] Q As of November or December 2002 to the best of your knowledge did doctors order checks on suicidal inmates that were more frequent than 15 minutes?

A That has happened, yes.

Q Do you know if it happened at that point or prior to that point?

A Prior.

Q So the doctors – let me back up. Not so much doctors, but the med staff as a whole were aware they could authorize anything from constant observation to half an hour checks to something less frequent?

A That's my recollection.

Q You were queried, I believe, about clear plastic doors or clear doors for inmates on suicide precautions. Could feces cover those doors very quickly?

A Yes.

Q Would it be practical to clean that door fast enough to secure the inmate?

A You would have to remove the inmate from the cell and then clean it and then put the inmate back in.

[114] Q Is it your belief that inmates of that nature put in there because of suicide precautions would indeed do that to the doors on a somewhat regular basis?

A The inmates are very creative in their use of feces.

* * *

[122] Q If medical wrote an order for constant observation, could that be implemented? As things stood in December of 2002 could that have been implemented?

A I believe you could have, yes.

Q How?

A By putting an officer on the inmate.

Q Right outside the door?

A We have done that.

* * *